CLINICAL PROFILE OF OBESE PATIENTS

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I hereby declare that the thesis entitled "**CLINICAL PROFILE OF OBESE PATIENTS**" submitted towards partial fulfillment of the requirements for the award of **MD in MEDICINE** degree to BFUHS is a compilation of original work carried out by me under the supervision of Dr Vipin Kumar, Associate Professor, Department of Medicine, Dr. Sandeep Puri, Professor, Department of Medicine, Dr Harmeet Singh Dhooria, Associate Professor, Department of Medicine. No part of this thesis has formed the basis for the award of any degree previously.

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Dedicated
to
my
Family
&
Teachers

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LIST OF ABBREVIATIONS

BMI	Body mass index
WHO	World health organization
ICMR-INDIAB	The Indian Council of Medical Research–India Diabetes
NIDDM	Non-insulin dependent diabetes mellitus
CHD	Coronary heart disease
MONICA	Monitoring of trends and determinants in cardiovascular diseases
NHANES	National Health and Nutrition Examination
US	United states
WHR	Waist hip ratio
CAD	Coronary artery disease
LDL	Low density lipoprotein
HDL	High density lipoprotein
OSA	Obstructive sleep apnoea
FDA	Food drug administration
DMCH	Dyanand medical college
DM	Diabetes mellitus
HTN	Hypertension
HbA1c	Glycosylated haemoglobin
LV	Left ventricle
CVD	Cardio vascular disease
OR	Odds ratio
NAFLD	Non-alcoholic fatty liver disease

ABSTRACT

INTRODUCTION: Most widely used method to gauge obesity is body mass index. BMI of >30kg/m^2 is obese for both male & female.

AIMS AND OBJECTIVES: 1) To evaluate indication for admission in obese patients who are admitted in medical wards.

2) To assess outcome of admitted obese patients

3) To collect data for clinical profile of obese patients

MATERIAL AND METHODS: An observational study at DMCH, Ludhiana. Study period 1 year, obese patients with BMI >30kg/m^2, admitted to medicine wards were analysed for their presenting complaints, co-morbidities and body system involved.

RESULTS: Total 216 admitted obese patients were enrolled. Prevalence of obesity is more in males than females i.e. 46.3% females & 53.7% males. BMI minimum 30 with ranging up to maximum 48, with mean 36.2 and standard deviation 4.7. Maximum number of obese patients in age group >50 years with BMI 30-35 kg/m^2 (87 cases; 71.9%); BMI >40 kg/m^2 were (32 cases; 76.2%). Obesity prevalence more in urban population (109 cases; 50.5%) than rural (107 cases;49.5%).with increasing BMI, waist hip ratio was high, BMI range 30-35 kg/m2 65.7% cases, in BMI range 36-40 kg/m2 and above 40 kg/m2, 100% cases.169 (78.9%) subjects out of 216, were Diabetic. Diastolic dysfunction (15 cases; 12.4% in BMI 30-35 kg/m2 group and 6 patients, 14.3% in BMI >40 kg/m2 group) obese. 20 cases (9.26%) systolic dysfunction. Patients within BMI range >40 kg/m2 had 97.6% OSA prevalence. Hospital stay duration longer with higher BMI, patients, BMI >40 had mean of 19.1; BMI 30-35 was 6.9, p-value 0.0001. Hypothyroid and hypertension patients more mortality rates 53.5%; 69.8% and p-value 0.048 and 0 respectively. Dyslipidemia higher mortality 90.7%; p-value 0.

CONCLUSION: Obesity more prevalent in urban population, male population, non vegetarian diet, age group >50 years. More comorbidities, longer hospital stay.

KEYWORDS: Obesity, BMI, mortality

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INTRODUCTION

1. Obesity is reaching epidemic proportions globally. It has nearly tripled since 1975, worldwide as per WHO.[1] It accounts for 2-6% of total healthcare costs in several developed countries, some estimates put the figure as high as 7%. More than 1.9 billion adults, 18 years and older, were overweight. Of these over 650 million were obese, in 2016.[1] As stated in world health report of 2002, it is seen that there will be 1/3rd loss of healthy life as a result of overweight and obesity in the year 2020 compared with 2000.[2]
2. The rising epidemics are reflecting the profound changes in society and in behavioral pattern of communities over recent decades. Two critical factors that have influenced, the occurrence of obesity are changes in dietary patterns and levels of physical activity, which accompany the lifestyle changes that are taking place. Urban India report suggests that prevalence of obesity varies with socio economic status.[3] More than 135 million individuals were affected by obesity, in India. The Obesity prevalence in India is varying due to age, gender, geographical environment and socio-economic status. Prevalence rate of obesity and central obesity are varying from 11.8% to 31.3% and 16.9%–36.3% respectively, according to ICMR-INDIAB study 2015.[4]
3. Obesity is spreading into developing countries, which was earlier considered a buy product of modern life in rich, developed countries. In developing world, it is creating the worst of both worlds- the double burden of incompletely solved under nutrition and rapidly emerging epidemic of obesity and related diseases. In developing countries in Asia, Malnourished populations may have an increased predisposition to obesity and more specifically abdominal obesity. The casual link is that recovery from episodes of under nutrition results in alteration in body composition with increase in the amount of fat gained and probably intra-abdominal fat. This is further supported by demonstration of Dutch famine showing the prenatal effect of refeeding on subsequent obesity.[5]

4. Obesity is often defined simply as a condition of abnormal or excessive fat accumulation in adipose tissue, to the extent that health maybe impaired. The underlying cause is the undesirable positive energy balance. However, obese individuals differ not only in the amount of excess fat that they store, but also in regional distribution of that fat in the body. Mortality and morbidity vary with the distribution of body fat, with the highest risk linked to excessive abdominal fat (central obesity). The central obesity is related to a number of diseases, including cardiovascular disease and non-insulin dependent diabetes mellitus (NIDDM). In certain populations, including such as those of Asian descent, central obesity is recognized to be better predictor of co morbidity than body mass index (BMI).[6] It is seen that Asians are having low body mass indices relatively but high levels of abdominal fat and particularly prone to NIDDM, hypertension and CHD. Almost 20% of adults who were not overweight or obese still had central obesity making them predisposed to a greater risk of developing the associated diseases, as per an Indian study.[7]

5. **The burden of disease**

5(a) **Global aspects**

WHO states, as per the current trends, it is estimated that it will be 2.7 billion adults who will be overweight, over 1 billion will be affected by obesity, and 177 million adults will be severely affected by obesity by 2025.[8]

WHO MONICA (Monitoring of trends and determinants in cardiovascular diseases) project has most comprehensive data on prevalence of obesity worldwide are those.[9] BMI distribution in 48 MONICA populations for men and women were studied and concluded that, in all but one male population and majority of female populations, between 50-57% of adults aged 35-64 years were either obese or overweight.

Reports of 1999-2000 National Health and Nutrition Examination surveys (NHANES), using measured heights and weights indicate

the estimated 64% US adults are either overweight or obese. It is observed that prevalence of obesity has increased considerably over the years. When age adjusted estimates from NHANES III (1988-94) for adults age 20-74 years were compared with prevalence estimates from NHANES II (1976-1980, there was notable increase in the prevalence of persons who were either overweight or obese (BMI >25). Similarly, among adults aged 20-74 years, the estimated prevalence of obesity (BMI > 30) has doubled between NHANES II and NHANES 1999-2000 from approximately 15% to an estimated 31%.[10]

Age- adjusted prevalence of overweight and obesity among U.S adults age 20-74 years:

	NHANES II (1976-80) (n=11, 207)	NHANES III (1988-94) (N=14, 468)	NHANES 1999-2000 (n=3, 601)
Overweight or obese (BMI >25.0)	47	56	64
Obese (BMI >30.0)	15	23	31

The national health objectives in USA for the year 2010 are to reduce the prevalence of obesity among adults to less than 15%.

High prevalence has been reported in several developing countries including the Asian region as well. A national nutrition survey in 1995 in Republic of Korea, found 1.5% population obese and 20.5% as overweight. In Thailand 4% was obese and 16% as overweight. In Malaysia, 4.7% men and 7.7 % of women were obese. As low as <5% level of obesity was noticed among men and women in China and Japan.[11]

5(b) **Indian scenario**

In adults aged 20–69 years between 2010 and 2040, the prevalence of overweight will more than double among Indian, while the prevalence of obesity will be triple. It is estimated that the

prevalence of overweight and obesity will reach 30.5% (27.4%-34.4%) and 9.5% (5.4%-13.3%) among men, and 27.4% (24.5%-30.6%) and 13.9% (10.1%-16.9%) among women, respectively, by 2040. It is expected that largest increases in the prevalence of overweight and obesity between 2010 and 2040 is expected to be in older ages, and a larger relative increase in overweight and obesity in rural areas compared to urban areas.[12] A recent report from the Kashmir valley in adults showed the obesity prevalence to be 15% with females having a higher prevalence of 23.7% as compared to 7% among males.[13]

The prevalence of obesity in ethnic Punjabi population is not reliably clear. As per study stated, 21% population of rural Punjab is obese. Risk of comorbidities is substantial in this ethnic group, viz hypertension, cardiovascular disease,[14] gall bladder disease, carcinoma breast, diabetes mellitus. To make recommendations for prevention and management of obesity, it is important to known prevalence of obesity, clinical profile of obese patients. Hence, this study was planned.

6. Scope for prevention

There are a range of long term strategies for effective weight management for individuals and groups at risk. It includes management of comorbidities, weight loss, and weight maintenance. Approach must be integrated, multi-sectoral, population based approach. Environmental support must be there for healthy diets and regular physical activity. There is a burden of cost viz direct cost of obesity, cost in terms of individuals (ill health, reduced quality of life (intangible cost)) and loss of productivity due to sick leave and premature pensions (indirect cost). Prevention is therefore more cost effective than treatment itself. The importance of obesity has to be appreciated by health care workers and policy makers. Effective policies and programmes are needed to prevent obesity.

AIMS AND OBJECTIVES

Obesity is a major health problem, yet neglected and under studied.

1. To evaluate indication for admission in obese patients who are admitted in medical wards.
2. To assess outcome of admitted obese patients.
3. To collect data for clinical profile of obese patients.

REVIEW OF LITERATURE

1. Among different morbid conditions, that are constantly disabling the mankind, obesity has been increasing at an alarming rate in the developed nations and in recent years in developing countries as well. Latin origin word, Obesus, OBESE means 'to eat'. A chronic excess energy intake than of energy expenditure, resulting in weight gain and positive energy net balance. Metabolic functions are altered, as contributed by two factors, total body fat and adipose tissue regional distribution. Obesity is associated with many morbid conditions, as per the latest list, forty-five diseases to number. The leading ones are, coronary artery disease, stroke, diabetes and certain cancers. Obesity is a disease itself, rather than being just a health risk factor.
2. Obesity is not only having increasing trend in adult population, but paediatric population is also facing a new health hazard, which is becoming a threat globally, and is a big challenge across the world. The term given to the paediatric population obesity is 'childhood obesity'. In children of US as well as children of Asian countries, the prevalence of obesity has shown an increasing trend in between 1980 and 1994.[15]
3. The recent epidemic of obesity in children[16] is raising concern because of clinical as well as public health consequences.[17] Childhood obesity is a cosmetic issue, as per a wide spread perception among the health personals, and has minor clinical effects. Long term adverse effects of childhood obesity are well established. There is a strong link between childhood morbidity and mortality in adulthood, as the cardiovascular effects of obesity in childhood persists.[18]
4. There is familial tendency of obesity which is well contributed by genetic and environmental factors. The maternal obesity is associated with increased subcutaneous fat in the new born. As there is increased placental free fatty acid transfer, inheritance and decreased activity in obese maternal patients.[19]

5. There is strong relationship between BMI and mortality in adults and children, but relationship between BMI and mortality amongst adolescence has been observed to be on a lesser extent. There have been other negative effects of obesity observed in adolescents [20] Adverse effects like, early maturation, increased central deposition of fat,[21] and lasting social effects on self-esteem and body image.[17, 21, 22] Obesity in childhood /adolescence also play an important role to predict adult obesity.[20, 23] There is a shortage of Research including long term follow up data.[24]
6. Classification of the weight status of children and adolescent is complicated due to the reason that the body composition and height is constantly changing in them. And this change often occurs at different times and rates in different group of populations. Therefore, age and gender specific growth curves are needed to be used to define overweight and risk for overweight. International obesity task force workshop proposed.[25]
7. Cole et al proposed age and gender specific cut-off points to define overweight and obesity.[26] For under five years' age group, 4 different charts have been designed, >5-10 years, >10-18 years, and adults to delineate the normal range, underweight, overweight and obesity on above charts. The three-in-one weight, height and built in BMI charts are applicable to both genders and all age groups including children and adults and are appropriate for mass screening as well.[27]
8. In adults, body mass index is often used to classify underweight, overweight obesity. Body mass index is defined as the weight in kilograms divided by the square of the height in meters (kg/m2). The recommendation for BMI classification by WHO, has been shown in the following table.[28] It includes an additional subdivision at BMI 35.0-39.9 in recognition of the fact that management options for dealing with obesity differ above a BMI of 35.

Classification of adults according to BMI as per WHO criteria:

Classification	BMI
Underweight	<18.50
Normal range	18.50-24.99
Overweight	>25.00
Pre-obese	25.00-29.99
Obese class-I	30.00-34.99
Obese class-II	35.00-39.99
Obese class-III	>40.00

8. Nuttal FQ et al, proposed the use of W/H^P, where the power function 'p' is derived specifically for each population group. This study recommended use of either relative weight or a power type index with 'p' rounded to the nearest whole number to make computations easy. It was observed that the closest integer of 'p' is 2 and hence it maybe concluded that W/H^P in population and thus found most useful in practice.[29] It has been observed that within the same population, BMI can be used to estimated prevalence of obesity and the risks associated with it. But BMI, does not account for wide variation in the nature of obesity among different individuals and populations. It is a fact, that for same BMI, different population and ethnic groups have quite different amount of body fat. For the same BMI of 20, it has been studied that individuals from rural India, Ethiopia and Papua New Guinea had 12%, 7% and 1% of body fat respectively.[30] To assess the risk of obesity related illness due to abdominal fat collection, other methods in addition to BMI are needed.
9. Waist circumference is a convenient and simple measure that is unrelated to height.[31] Waist circumference in linked closely to BMI and WHR (waist hip ratio).[32] It is approximate index of intra-abdominal fat mass[33,34,35] and total body fat.[36] The changes in waist circumference reflect changes in risk factors for cardiovascular disease[37] and other forms of chronic disease, even though risk

seems to vary among different populations. A measure of more than 102 centimeters (40 inches) in men and 88 centimeters (35 inches) in women indicates health risks, especially if one has a BMI of 25 or more.[38]

10. Some experts like to consider the hip measurement provides added information related to gluteo-femoral muscle mass and bone structure.[39] The WHR remain a useful research tool. Over the past 10 years or so, it has been accepted that a high WHR (WHR >1.0 in men and >0.85 in women) indicates abdominal fat accumulation.[31] An Indian study stated that ideal WHR in Indians should be below 0.95 in men and 0.80 in women.[38]
11. Other tools, including anthropometric measures available for the more characterization of obese state includes methods of measuring body composition (e.g. underwater weighing, determining the anatomical distribution of body fat (e.g. prospective dietary record) and energy expenditure. The practical applicability and the cost of such techniques and the difficulties faced with them, limit their usefulness to research.

Over a considerable period of time, then imbalance of energy consumption and energy expenditure leads to obesity. Many complex factors and diverse etiologies can give rise to positive energy balance, but it is interaction amongst these factors, which results in obese state of body, thus obesity is multifactorial problem.

12. Factors responsible for obesity

12(a). Diet and Nutrition

Dietary factors can be considered to be the major modifiable factors through which many of the external forces are promoting weight gain act. As populations become more urban and incomes rise, diets rich in complex carbohydrates give way to more varied diets with higher proportion of fats, saturated fats and sugars. Dietary fat has a higher energy density than other macronutrients and thought to be largely responsible for overeating effect. Fibers, by contrast, are limiting

energy intake by lowering foods density and allowing time for appetite control signals to occur before large amounts of energy have been consumed. Efficacy-based data on the effects of exercise (and also a sedentary lifestyle) on abdominal obesity, visceral fat, and metabolic risk is explained by a study 'Exercise, Abdominal Obesity, Skeletal Muscle, and Metabolic Risk: Evidence for a Dose Response'.[40]

Regular (high fat) snacks have been associated with increased overall dietary intake in different societies, but these conclusions remain controversial.[41] Easy availability of junk foods in rural areas, is responsible for increased prevalence of obesity in these areas. Other evidence from different societies suggests that dietary restraint and sliming leads to skipping breakfast and that this may result in over consumption later in the day.[42] Since it has been established that junk foods are associated with obesity, governments must wage a multipronged and sustained campaign to counterbalance the food industry marketing efforts which can help the society to overcome obesity related issues.[43]

12(b). **Physical Activity**

Physical activity patterns have an important impact on the physiological regulation of body weight. In particular, they affect total energy expenditure, fat balance and food intakes. Cross sectional data often reveal an inverse relationship between BMI and physical activity,[44-47] which indicates that obese and overweight subjects are less active than their lean counterparts. Furthermore, the secular trend in the increased prevalence of obesity seems to parallel a reduction in physical activity and a rise in secondary behavior.[48] One of the best examples of this is provided by Prentice and Jebb, [50] who used crude proxies for inactivity, such as the amount of time spent viewing television or the number of cars per household. Recently, it has been proved that there is a direct correlation between hours spent watching television and the risk of obesity and

also that unorganized sports like street hockey and bike riding are the best for preventing childhood obesity.[49]

12(c). **Genetic Susceptibility**

The role of genes, in gaining weight is the topic of interest for research and hence discovery of leptin*,* a hormone produced by adipocytes, has led to a renewed interest in genetic and metabolic influences in the development of obesity.

Obesity runs in families; obese parents tend to have obese children. Allison et al*,* published one of the first papers on this topic,[51] which concluded that there was relative risk of 2, for children having overweight parents and the risk is increasing to above 3-4 for higher levels of obesity. The studies on twins and adoption studies have suggested that human obesity can have a significant genetic component, with the heritability of the body fatness varying between 25% and 90%.[52] Leptin, a circulating product of obesity gene recreated by adiposities is most crucial in regulating body weight, as per recent research. The rate of leptin production and circulating leptin is directly related to fat mass.[52]

12(d). **Neurotransmitters**

Different research work has revealed that dopamine, serotonin, neuropeptide y, orexin, ghrelin, acetylcholine and nor epinephrine play an important role in control of appetite, satiety and pathophysiology of gaining weight leading on to obesity.[53-54]

12(e). **Socioeconomic Status**

As per capita income increases, the nature of the diet in traditional society tends to change in a pervasive and well documented manner. In particular, intake of animal protein increases and animal fat tends to increase. And the intake of vegetable fat and protein tends to decrease, those of total and particularly complex, carbohydrates also decrease and those of sugar increases.

The study by nutrition foundation of India stated that the prevalence of obesity in urban Delhi, one third of males and more than half of females belonging to upper middle class were overweight. The

prevalence of abdominal obesity in this group was even higher.[55] And also, the level of education is inversely associated with body weight in industrialized countries. The inverse relationship between education and overweight maybe partly attributed to the basic fact that individuals of higher education level are more likely to follow dietary recommendations and are more likely to adopt the other risk avoidance behaviors than the low educational attainment people. [56]

12(f). **Cultural Influence**

Culture affects both physical activity and food intake pattern, although the "cultural attributes" responsible are not well characterized and accurately measured at present situation.

The practice of breast-feeding though universal, is very culture sensitive. Early and prolonged breast feeding is a common practice in many developing countries and seems to protect against the development of obesity in childhood and adults. This theory has been supported by study of 'Julie Armstrong and colleagues' on breast feeding in Scottish children.[57] Breast feeding is also associated with lower blood pressures later in life, improved cognitive development and other benefits.[54,55]

12(g). **Alcohol**

Body is unable to store alcohol, and oxidation of ingested alcohol is given priority over that of other macronutrients. Alcohol consumption hence meets body's energy needs to some extent, allows greater proportion of energy from other foods eaten to be stored and is thus associated with an increased risk of abdominal fat.[58]

12(h). **Smoking**

Smoking causes a marked increase in metabolic rate and hence tends to reduce food intake compared with that of non-smoker population. [59] There is an inverse relationship between smoking and body weight.[60] Smokers often gain weight when they give up smoking. A nationally representative cohort of smokers and non-smokers in the USA found that the mean weight gain attributable to smoking cessation was 2.8kg in men and 3.8kg in women. However,

heavy smokers (more than 15 cigarettes per day), and younger people were at higher risk of major weight gain (>13 kg) after giving up smoking.[61] However, for obvious reasons due to other risks associated with smoking, promotion of smoking for weight reduction is not recommended.

12(i)**. Age**

In developed countries the natural pattern with age is an increase in body weight with ageing, at least up to 50-60 years old (in both men and women). The relationship between obesity and age is similar in developing countries, but the maximum rates of obesity tend to be reached at an earlier age (e.g. 40 years old). The decline in prevalence after this peak is thought to be partly attributed to lower survival rate of obese individuals.[62]

12(j). **Sex**

A number of physiological processes are believed to contribute to an increased storage of fat in females. Females have a tendency to channel extra energy into fat storage while males use more of this energy for protein synthesis. A report from the Kashmir valley in adults studied by multi-stage sampling showed the obesity prevalence to be 15.0% with females having higher prevalence of 23.7% as compared to 7.0% among males.

12(k). **Drug Treatment**

Adults on long term use of drugs like tricyclic antidepressants, lithium, sulphonylureas, beta adrenergic blockers, some steroid contraceptives, corticosteroids, insulin, valproic acid etc. maybe at an increased risk of developing obesity.

12(l). **Disease states**

Certain genetic disorders, as well as some endocrinological conditions such as hypothyroidism, Cushing disease and hypothalamic tumours can lead to weight gain.

13. **Health Consequences of Overweight and Obesity**

There are many health consequences of obesity ranging from increased risk of premature death to several non-fatal but debilitating complaints that have adverse effect on quality of life. Abdominal obesity is of concern as it is associated with increased risk to health than the peripherally distributed fat. The risk of co morbidities is much higher among South Asians (India, Pakistan, Bangladesh) and at a lower BMI range (63,64). It is further complicated by variation in pattern of accumulation of fat (whether central or peripheral) in different origin communities. People differ in their level of risk associated with abdominal obesity and it is worth noticing that the south Asians show a disproportionate increase in this risk.[65]

13(a). **Coronary Heart Disease**

CHD is the major cause of premature death in most affluently rich society of people. But the rate of these diseases are declining in developed countries, they continue to rise in some part of the world, especially in countries like Eastern Europe and Asia.[66] The leading cause of global morbidity and mortality by 2021, is atherosclerotic diseases.[67] This trend has grave consequences for countries in South Asia.[68]

Epidemically, obesity as a disease is evident in indigenous populations who have undergone rapid accumulation from their traditional lifestyles and most of the cases are expected from China and India.[69] Highest rate of CHD was found in Asian Indians. CHD occurs at an early age and generally follows a severe and very progressive course. But the prevalence of classic risk factors is relatively very low, there is substantial prevalence in this population of high triglycerides and low HDL cholesterol levels, high lipoprotein levels, hyperinsulinemia ad abdominal obesity.[70]

Prospective study suggests that obesity is an important independently identified risk factor for CHD. It was stated in Framingham heart study that the body weight is third most

important predictor of CHD among males, after age and dyslipidaemia.[71] Likewise, in females, a large scale prospective study in the USA reported that there is a positive correlation between BMI and the risk of developing CHD.[72] In younger age groups, the risk of CHD associated with obesity is higher than those in excess fat around hips and thighs. [73]

In CHD patients, 70% to 88% are overweight.[74,75] A study was conducted in 186 young adults (20-40 years) and 177 older adults (41-70 years) with an aim to assess the association between measures of obesity and aortic stiffness. It was found in the results that among both young and older adults, body fat measures were among the strongest independent predictors of aortic stiffness.[76]

A case control study, hospital based, had 200 cases enrolled, with angiographically documented CAD and 200 age and sex-matched controls without angiographic evidence of CAD conducted in Pakistani population, reported that the cardiovascular risk profile in this population is consistent with metabolic syndrome where low HDL and WHR can be used to predict risk of CAD.[77]

13(b). **Hypertension**

The correlation between hypertension and obesity is well known. It is known that, both systolic and diastolic blood pressure increases with BMI, and obese are at higher risk of developing hypertension than lean individuals.[78] It has been estimated that a 10% increase in body fat leads to 6mm rise in systolic and 4mm rise in diastolic blood pressure. Community wide surveys in USA (NHANES-II) show that the prevalence of hypertension in overweight adults is 2.9 fold higher than that for non- overweight adults. [79] The risk in those aged 20-44 years is 15.6 times greater than that in those aged 45-74 years.[80] Which in turn is twice as high as that for non-overweight adults.[81] The risk further increases with the duration of obesity. A study in Honolulu, in which 1163 non-smoking men aged between 55 and 68 years were examined, found that elevated BMI was associated with increased risk of thromboembolic stroke.[82]

13(c).**Diabetes**

Patients with diabetes worldwide will continue to increase at record levels through 2030, with greater relative increase in prevalence expected in the Middle Eastern crescent, sub-Saharan Africa and India. [83] Research have predicted that the number of people with diabetes globally will actually double over the next three decades and that the United States will experience far more rapid increase than previously expected. Indian studies have shown an alarming increase in the prevalence of type-2 diabetes in urban areas and it is predicted that by the year 2025, the maximum prevalence of diabetes would be in India and every 4th diabetic in the world will be an Indian [84]

There is a positive correlation between obesity and the risk of developing NIDDM has been repeatedly observed. The relationship between obesity and NIDDM has identified certain characteristics of obese persons that further increase the risk of developing this condition. These include obesity during childhood and adolescence, progressive weight gain from 18 years and intra-abdominal fat accumulation has been implicated as an independent risk factor for NIDDM and in some studies, has been an even stronger predictor of NIDDM then overall fatness.[85,86,87]

Central obesity, measured by WHR is associated with increased risk of diabetes mellitus in susceptible individuals. The adverse metabolic effects of visceral fat occur independent of subcutaneous or total body fat.[88] High proportion of abdominal fat, estimated by elevated waist circumference, is associated with an increased probability of developing diabetes mellitus as well as with cardiovascular disease related mortality, as per a prospective study. [89]

There is an increased risk of NIDDM with Lack of physical activity and unhealthy diet. There is a 2-4-fold higher prevalence of NIDDM in least physically active individuals compared with most physically active.[90,91] It is seen in a study, that Gujrat, in India has highest

number of diabetics, where sweet-meats (a sugar rich confectionary item) suitably modified for diabetic patients is available in market. As per studies, in Gujrat, 18-21% urban population and 3-5% of rural population is suffering from diabetes.[92]

13(c). **Cancer**

A list of cancers that is cancer of gall bladder, endometrium, colon, kidney, prostate and breast, oesophagus and gastric cancers are linked to obesity.[93,94] American cancer society study showed that obese males, regardless of smoking habits, had a higher mortality from cancer of colon, rectum and prostate.[95] The increased incidence of these cancers in obese people is greater in those with excess abdominal fat and is also a direct adverse effect of hormonal imbalance.[96] There is a positive association between breast cancer and total fat intake, as per a case control study.[97]

13(d).**Gallbladder disease**

For all age groups and in both men and women, gallstones occur three to 4 times more often in obese compared to non-obese people and more so, risk becomes higher if the fat is located around the abdomen. [98]

13(e). **Psychological Problems**

There are many psychological aspects to obesity which create significant amount of problem in obese patient's life. It is culture bound values by which people view the fat body as 'ugly' and 'unhealthy'. There was significantly higher dissatisfaction with body image in obese females than non-obese.[99] A Varanasi study, showed that obese women had more neurotic tendency than non-obese women.[100] Psychological issues were more with women than men, and were found to be more in chronically ill patients suffering from various chronic illnesses like rheumatoid arthritis, cancer or spinal injury.[101]

13(f). **Osteoarthritis and Gout**

The mechanical stress and metabolic changes in obese patient can lead on to development of osteoarthritis. The risk for gout maybe related with accompanying hyperuricemia, and central fat distribution especially in females.[102,103,104]

13(g). **Others**

There is a positive relationship existing between obesity especially intra-abdominal fat accumulation and risk of endocrinological disturbances,[105,106] dyslipidaemia and pulmonary diseases. Obstructive Sleep apnoea (OSA) occurs in more than 10% of men and women with BMI of 30 or above and 65-75% of people with OSA are obese. In a study, it was observed that sleep apnoea occurred in 77% of people with a BMI above 40. OSA is related to neck size and central obesity. [107,108]

14**. Prevention and Management**

Effective prevention and management of obesity should have consideration regarding aspects of cultural, social, political, physical and structural environment that affect the weight status of the community or population. There should be prevention of overweight in normal individuals, obesity in those who are already overweight and weight regain in those who have been overweight and obese in the past but who have now lost weight.

The initial goal of weight loss therapy for overweight patients is a reduction in body weight of about 10%. A 10% reduction in weight in 6months of therapy is a reasonable time period. The rate of weight loss should be 1 to 2 pounds per week, based on caloric deficit between 500 to 1000 kcal/day. The maintenance of lower body weight is the major challenge, once the body weight is achieved. Successful weight maintenance is defined as regain of weight that is less than 6.6 pounds (3 kilograms) in 2 years and a sustained reduction in waist circumference of at least 1.6 inches (4 cm).[109] After achieving a targeted weight loss, the combined

modalities of therapy (dietary therapy, physical activity and behavior therapy) have to be continued indefinitely. The patient has to keep a record of what they are eating and how they are exercising.[110]

Specific treatment for obesity is as simple as losing weight through diet and exercise. But, the diet plans fail to produce desired results and the lost weight is regained in majority of people.[111] Pharmacological therapies will help in weight loss when added to diet and exercise. In 1997, FDA approved sibutramine for long term use in obesity and in 1999, FDA approved orlistat for long term use. The option of surgery for weight loss is in trend now a days, for patients with clinically severe obesity >40 or BMI >35 with co-morbid conditions.

MATERIAL AND METHODS

It is an observational study which was conducted at DMCH, Ludhiana. In a study period of 1 year, obese patients with BMI >30kg/m^2, admitted to medicine wards were analysed for their presenting complaints and body system involved. Association of obesity with various co-morbidities was determined.

SOURCE OF DATA

The study included obese patients admitted in medicine wards of DMCH Ludhiana.

METHOD OF COLLECTION OF DATA

Inclusion Criteria

- BMI->30Kg/m^2
- Age- >18 years
- Patient's giving consent for the study

Exclusion Criteria

- Pregnant
- Ascites
- Age <18 years
- Patient's not giving consent

In this observational study, data from all obese patients BMI ->30Kg/m^2 admitted to tertiary care hospital in medicine wards with age over 18 years was collected. Co-morbidities associated with obesity were observed to determine the prevalence in obese inpatient population & the cause of admission for obese patients was analyzed, to determine clinical profile & outcome**.**

DURATION OF STUDY

1 Year

OUTCOME

The outcome of patients was recorded as follows:

The outcome of patient at the end of hospital stay i.e. discharged/ death, the predominant body system involved in the patient was observed.

FOLLOW UP

It was an observational study. No follow up.

STATISTICAL ANALYSIS

Data was described in terms of range; mean, standard deviation (SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. Comparison of quantitative variables between study groups was done using Student t-test and Mann Whitney U test for independent samples for parametric and non-parametric data respectively. For comparing categorical data, Chi-square (x 2) test was performed and the exact test was used when the expected frequency is less than 5. A probability value (p-value) less than 0.05 was considered statistically significant. All statistical calculations were done using SPSS (statistical package for the social science) SPSS 21 version statistical program for Microsoft Windows.

OBSERVATION AND RESULTS

The observation section has been divided into 21 subsections.

Table 1:- Distribution of obese patients (BMI >30 Kg/ m^2) in relation to Sex

GENDER	No. of cases	Percentage
Female	100	46.3%
Male	116	53.7%
Total	216	100.0%

The total sample of 261 subjects had 100 (46.3%) females and 116 (53.7%) males.

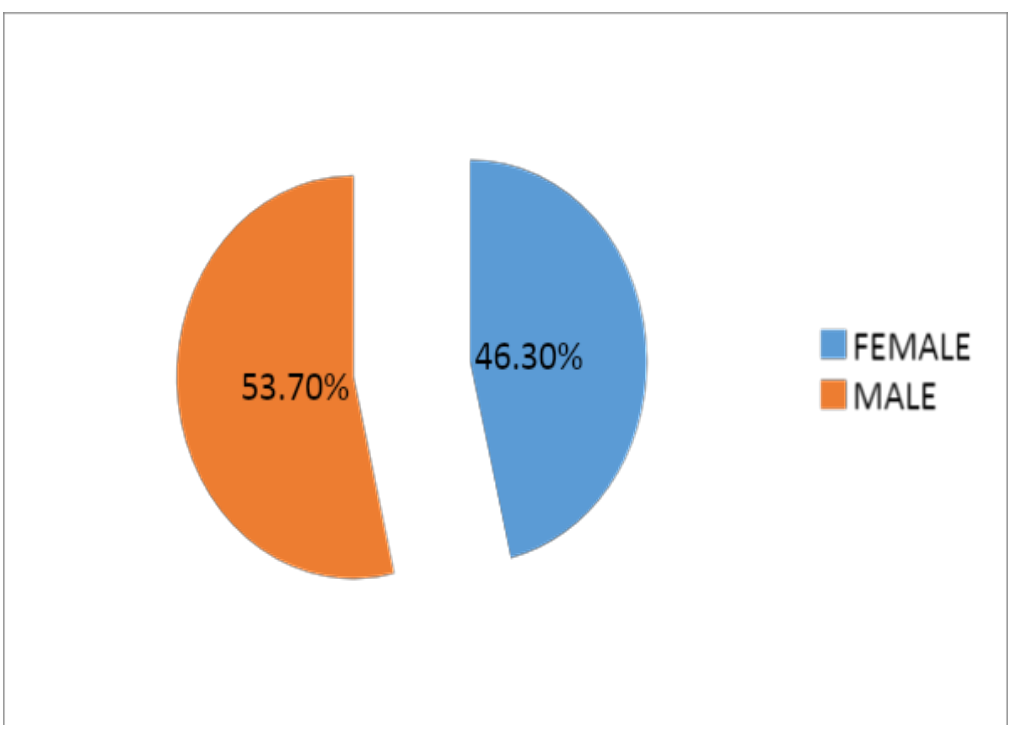

Figure 1:- Distribution of obese patients (BMI >30 Kg/ m^2) in relation to Sex

Table 2:-Distribution of obese patients (BMI >30 Kg/ m^2) in relation to Age

AGE GROUP (years)	No. of cases	Percentage
< 30	13	6.0%
31-50	39	18.1%
> 50	164	75.9%
Total	216	100.0%

Out of total 216 cases, the majority (75.9%) of the sample individuals were in the age group of >50 years. A very small proportion i.e. 6% in age group <30 years.

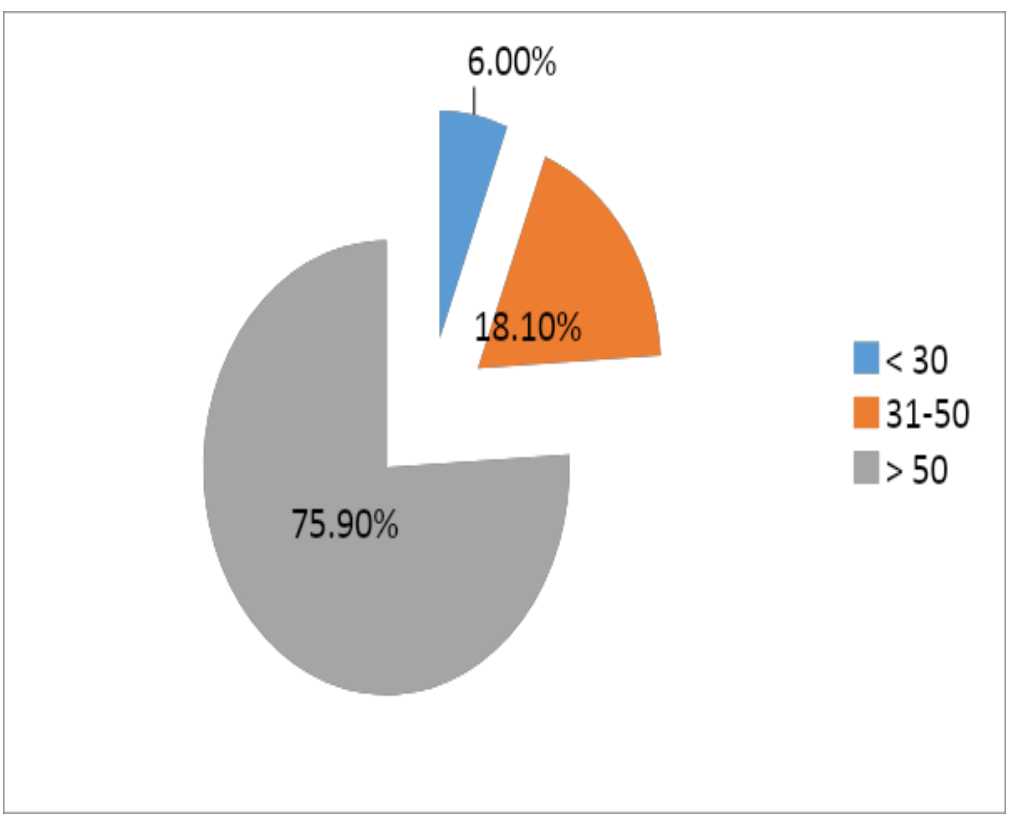

Figure 2: Distribution of obese patients (BMI >30 Kg/ m^2) in relation to Age

Table 3:-BMI wise distribution of obese patients (BMI >30 Kg/ m^2)

BMI Kg/ m^2	No. of cases	Percentage
30-35	121	56.0%
36-40	53	24.5%
> 40	42	19.4%
Total	216	100.0%

Among the study subjects, overall prevalence of cases with BMI >40kg/m2 making them morbidly obese were 42 cases (19.4%); there were 53 cases under BMI range 36-40kg/m2 and majority cases were within 30-35kg/m2 BMI range i.e. 121 cases (56.0%).

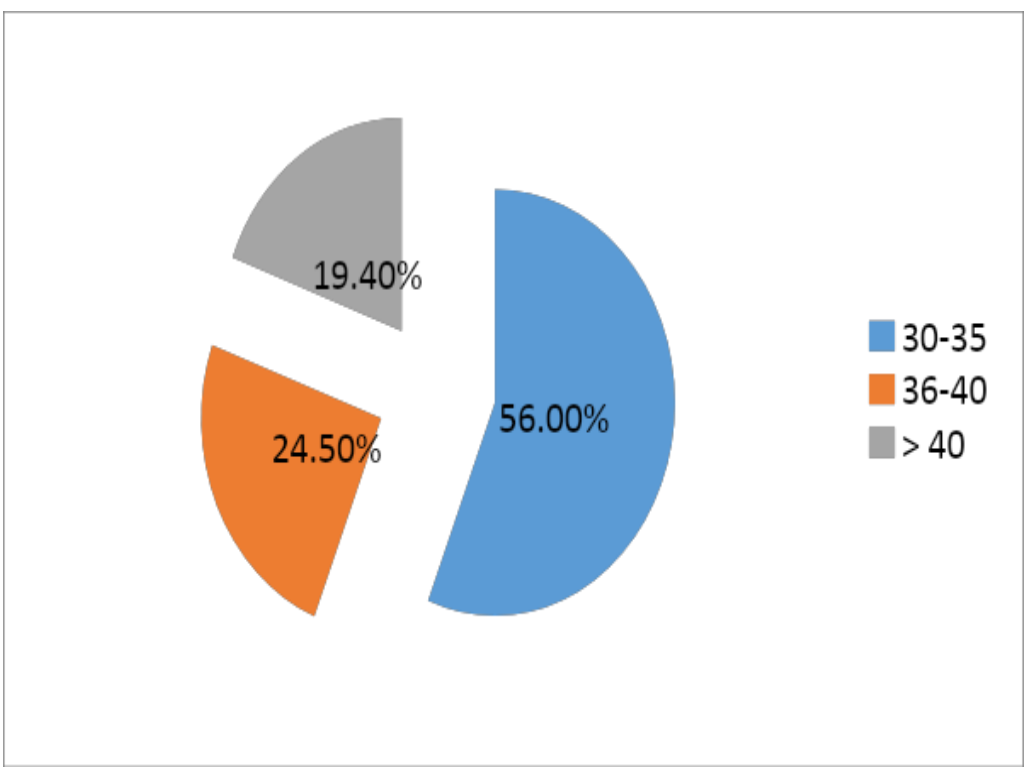

Figure 3: BMI wise distribution of obese patients (BMI >30 Kg/ m2)

Table 4:-Dietary habit wise distribution of obese patients (BMI>30 Kg/ m^2)

DIETARY HABITS	No. of cases	Percentage
Non-Vegetarian	145	67.1%
Vegetarian	71	32.9%
Total	216	100.0%

Among 216 cases, (145 patients) 67.1% cases had non-vegetarian dietary habits. Non-vegetarians were to be at higher risk of being obese than vegetarians (71 cases) 32.9%.

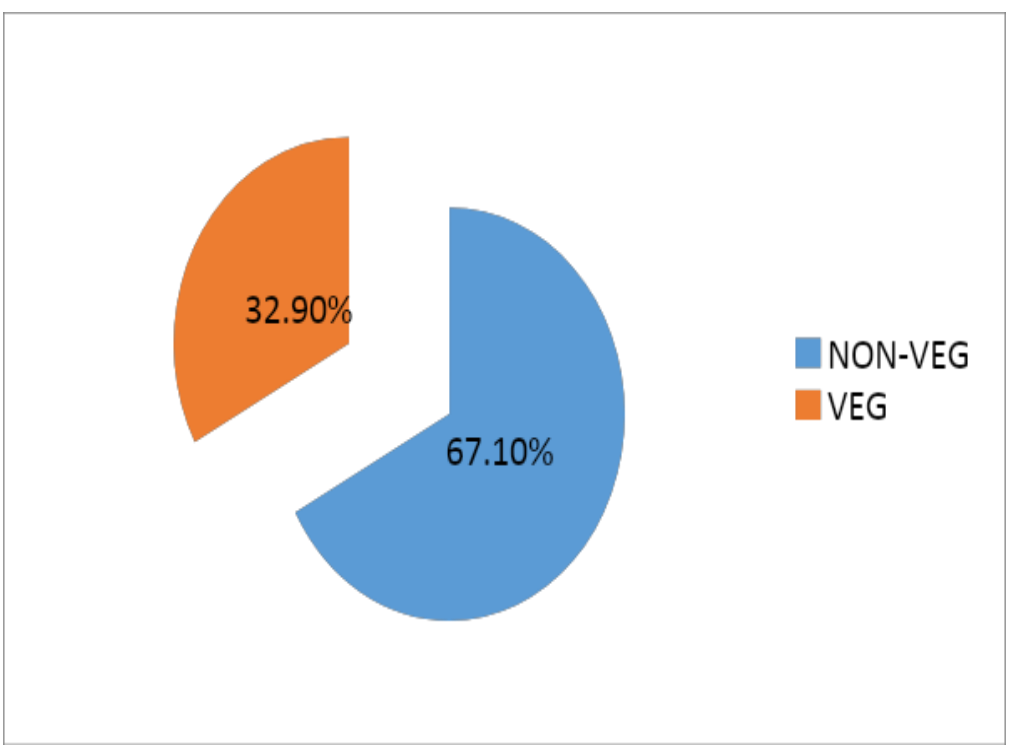

Figure 4:-Dietary habit wise distribution of obese patients (BMI>30 Kg/ m^2)

Table 5:-Distribution of obese patients (BMI >30 Kg/ m^2) in relation to Area

AREA	No. of cases	Percentage
Rural	107	49.5%
Urban	109	50.5%
Total	216	100.0%

The prevalence of obesity was slightly greater in urban subjects being 109 cases (50.5%) as compared to the rural subjects i.e. 107 cases (49.5%).

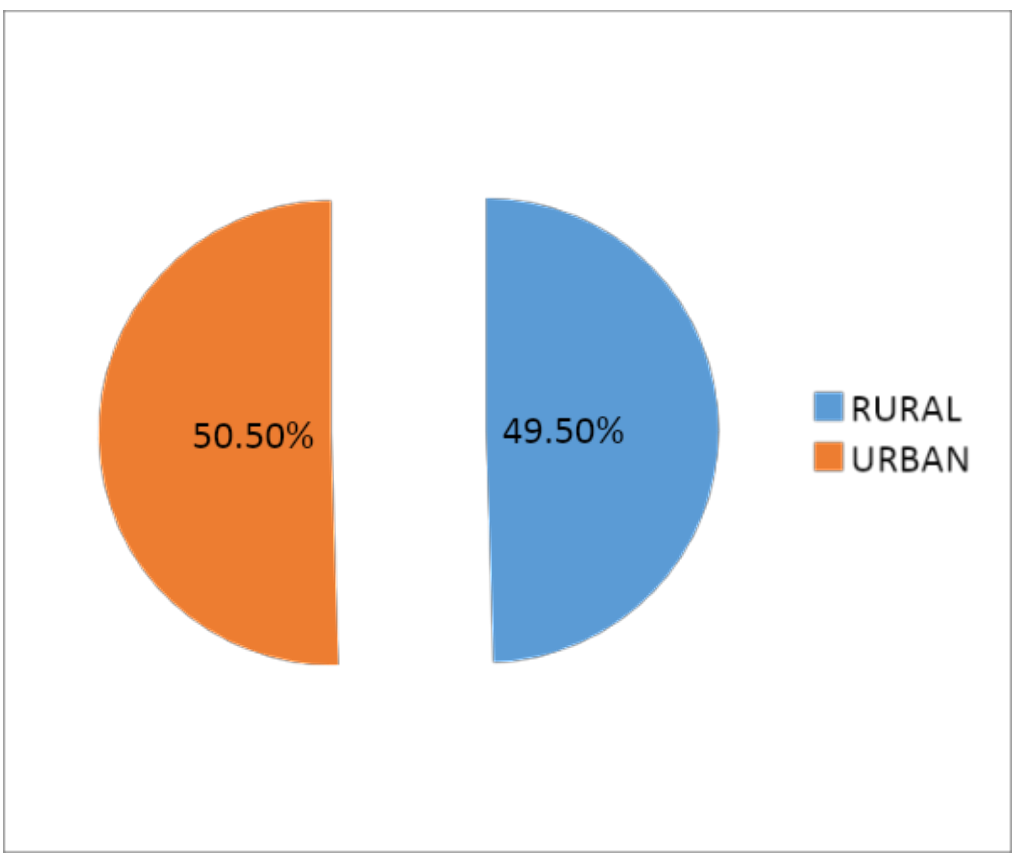

Figure 5:- Distribution of obese patients (BMI >30 Kg/ m2) in relation to Area

Table 6:- Prevalence of co morbidities in subjects in relation to obesity (BMI> 30 Kg/ m^2)

COMORBIDITY	No. of cases	Percentage
Type-II DM	169	78.2%
Hypertension	144	66.7%
Hypothyroidism	41	19.0%
Others	45	20.8%

Out of 216 cases, 78.2% had diabetes, 66.7% had hypertension, 19% were hypothyroid and 20.8% cases had other co-morbidities

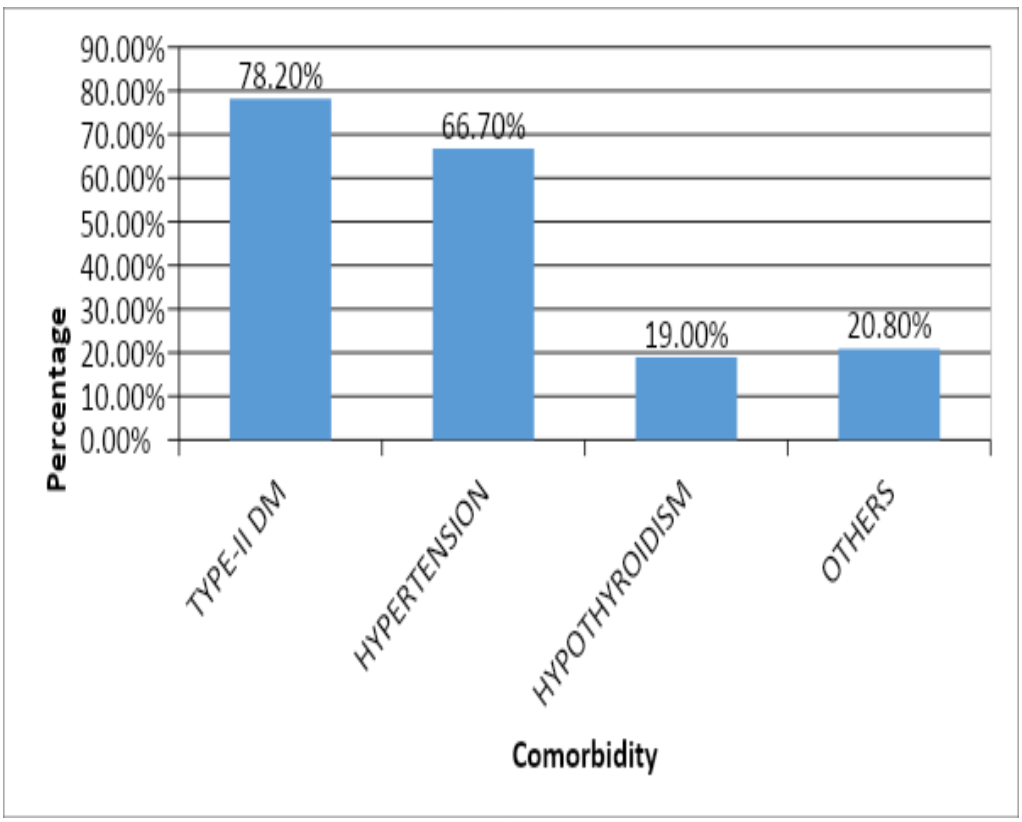

Figure 6:-Prevalence of co morbidities in subjects in relation to obesity (BMI> 30 Kg/ m^2)

Table 7:-Prevalence of fatty liver on ultrasonography in BMI> 30 Kg/ m^2

FATTY LIVER	No. of cases	Percentage
Present	131	60.6%
Absent	85	39.4%
Total	216	100.0%

In 216 cases, 131 cases i.e. 60.6% of patients had fatty liver.

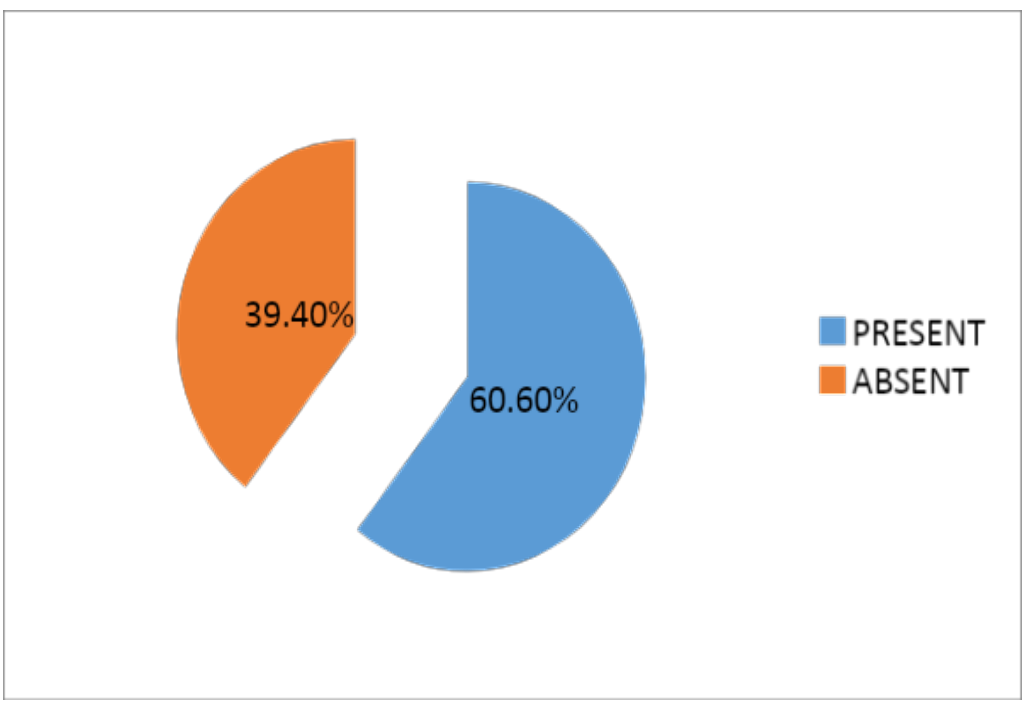

Figure 7: Prevalence of fatty liver on ultrasonography in BMI> 30 Kg/ m^2

Table8(A):- Distribution of subjects in relation to Echocardiography findings in Obese patients (BMI> 30 Kg/ m^2)

2D ECHO	No. Of Cases	Percentage
Systolic Dysfunction	20	9.26%
Diastolic Dysfunction	24	11.11%
Normal Echo	172	79.63%
Total	216	100%

Obesity impairs cardiac systolic as well as diastolic function. In this study, 24 cases (11.11%) had diastolic dysfunction and 20 cases (9.26%) had systolic dysfunction.

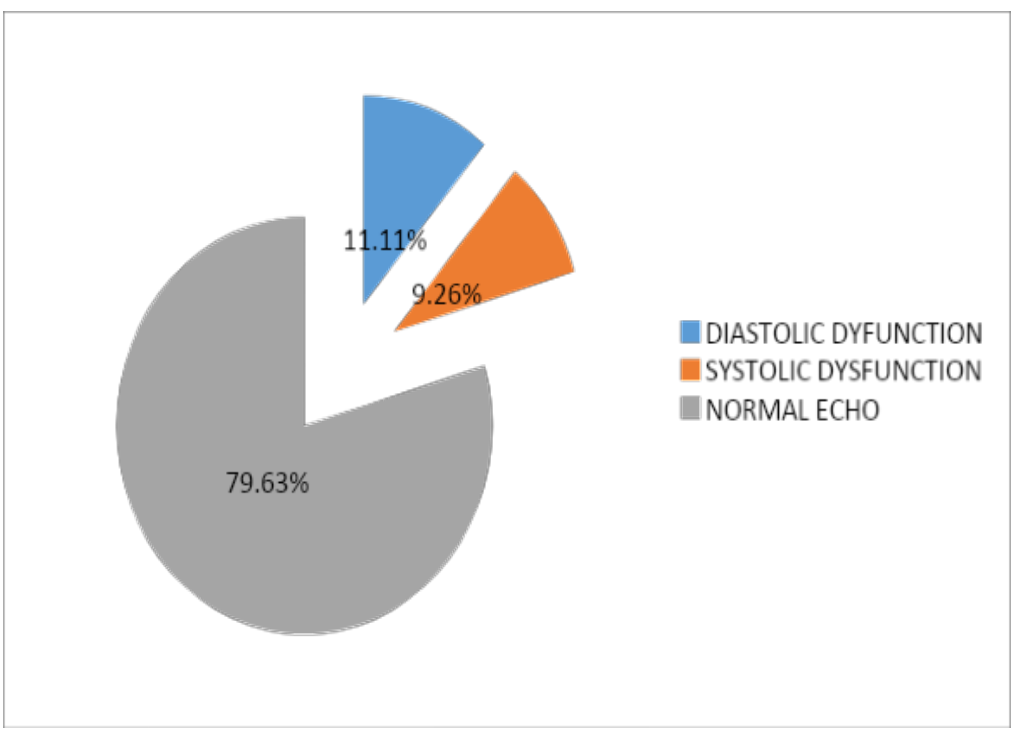

Figure8(A):- Distribution of subjects in relation to Echocardiography findings in Obese patients (BMI> 30 Kg/ m^2)

Table8(B):- Distribution of subjects in relation to Echocardiography findings in Obese patients (BMI> 30 Kg/ m^2) for specific BMI range.

	BMI						Total	Chi-square value	p-value
2D ECHO	30-35		36-40		> 40				
Diastolic Dysfunction	15	12.4%	3	5.7%	6	14.3 %	24	2.225	0.329
Systolic Dysfunction	7	5.8%	9	17.0%	4	9.5%	20	5.503	0.064
Normal Echo	99	81.8%	41	77.4%	32	76.2 %	172	0.832	0.660
Total	121	100.0 %	53	100.0 %	42	100. 0%	216		

Distribution of cases on the basis of echocardiography findings with respect to BMI (kg/m2)

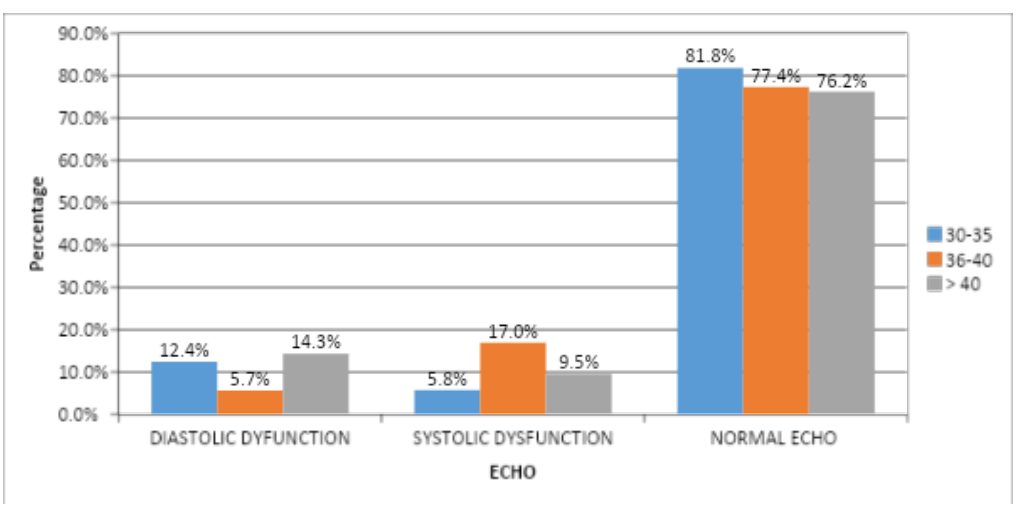

Figure8(B):- Distribution of subjects in relation to Echocardiography findings in Obese patients (BMI> 30 Kg/ m^2) for specific BMI range.

Table 9:-Distribution of subjects in relation to HbA1c in Obese patients (BMI> 30 Kg/ m^2)

		BMI						Total	Chi-square value	p-value
		30-35		36-40		> 40				
HbA1c	5-6.0	19	15.7%	6	11.3%	0	0.0%	25	74.062	0.000
	6-8.0	47	38.8%	21	39.6%	1	2.4%	69		
	8-10.0	35	28.9%	10	18.9%	4	9.5%	49		
	> 10	20	16.5%	16	30.2%	37	88.1%	73		

As the patients tend to be more obese, they have poor control of blood sugars as evidenced by glycosylated haemoglobin levels. In BMI >40kg/m2 range, 37 cases (88.1%) had glycosylated haemoglobin value >10.

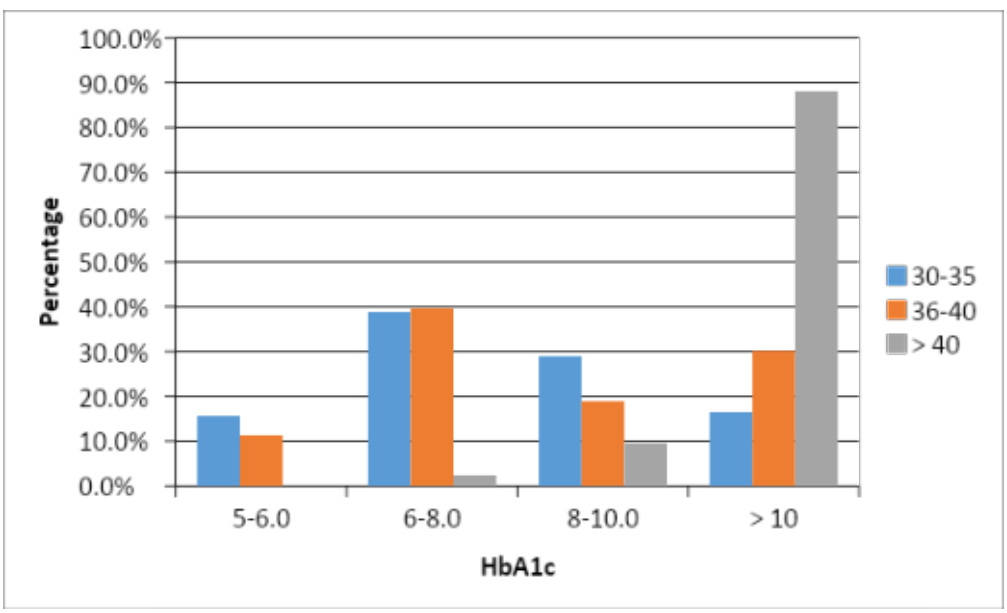

Figure 9:-Distribution of subjects in relation to HbA1c in Obese patients (BMI> 30 Kg/ m^2)

Table 10:-Distribution of subjects in relation to OSA in Obese patients (BMI> 30 Kg/ m^2)

		BMI						Total	Chi-square value	p-value
		30-35		36-40		> 40				
OSA	No OSA	85	70.2%	6	11.3%	1	2.4%	92	86.820	0.000
	OSA	36	29.8%	47	88.7%	41	97.6%	124		

As the BMI increased, OSA had more prevalence amongst obese patients. BMI >40kg/m2 range, 41 cases (97.6%) had OSA.

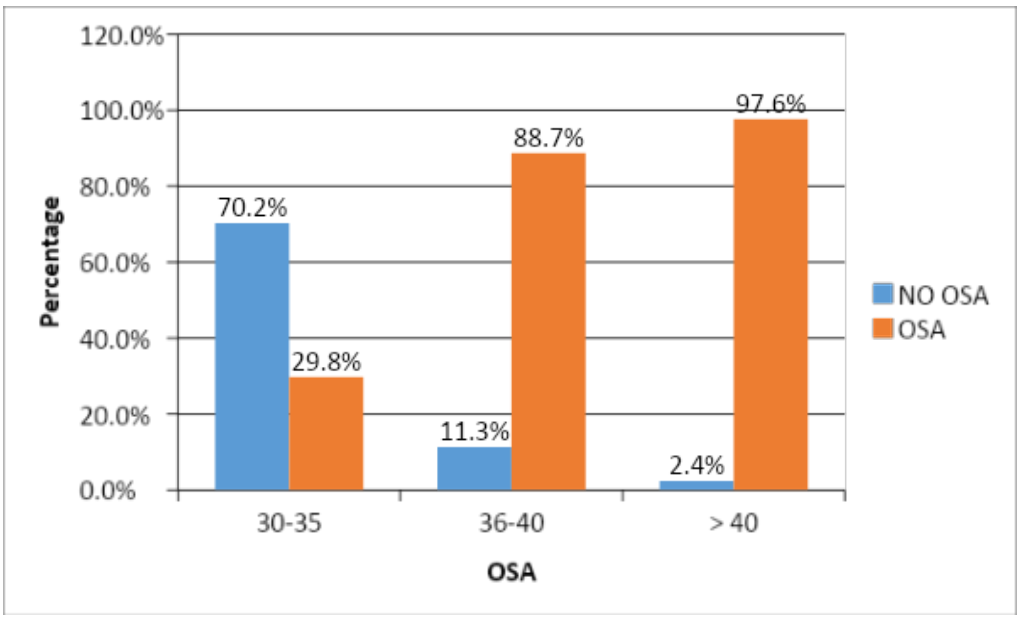

Figure 10:-Distribution of subjects in relation to OSA in Obese patients (BMI> 30 Kg/ m^2)

Table 11:-Relationship of waist hip ratio with respect to BMI in Obese patients (BMI> 30 Kg/ m^2)

		BMI						Total	Chi-square value	p-value
		30-35		36-40		> 40				
WAIST HIP RATIO (> 1.00 MALE/ >0.85 FEMALE)	WAIST HIP RATIO (< 1.00 MALE/ < 0.85 FEMALE)	38	31.4%	0	0.0%	0	0.0%	38	36.204	0.000
	WAIST HIP RATIO (> 1.00 MALE/ > 0.85 FEMALE)	83	68.6%	53	100.0%	42	100.0%	178		

Obese patients have dyslipidaemia, this study proved that as the BMI increases, more number of cases tend to have dyslipidaemia. In BMI 36-40 kg/m2 range, 100% of cases had deranged lipid profile, similarly in BMI >40 kg/m2 range, 100% of cases had deranged lipid profile

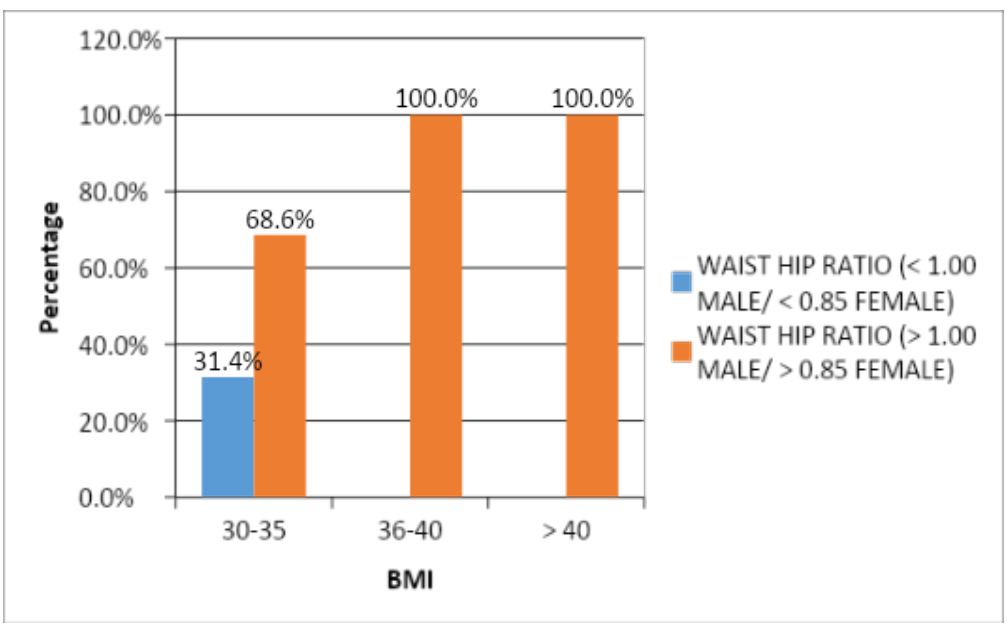

Figure 11:-Relationship of waist hip ratio with respect to BMI in Obese patients (BMI> 30 Kg/ m^2)

Table 12:-Lipid profile and fatty liver in Obese patients (BMI> 30 Kg/ m^2)

			BMI							TOTAL
			30-35	30-35	36-40	36-40	>40	> 40		
LDL	1	Less Than 160	118	97.5%	31	58.5%	1	2.4%		150
	2	More Than 160	3	2.5%	22	41.5%	41	97.6%		66
HDL	3	Less Than 40	33	27.3%	17	32.1%	30	71.4%		80
	4	More Than 40	88	72.7%	36	67.9%	12	28.6%		136
Triglycerides	5	Less Than 200	117	96.7%	30	56.6%	2	4.8%		149
	6	More Than 200	4	3.3%	23	43.4%	40	95.2%		67
Fatty Liver	7	No Fatty Liver	48	39.7%	21	39.6%	16	38.1%		85
	8	Fatty Liver	73	60.3%	32	60.4%	26	61.9%		131

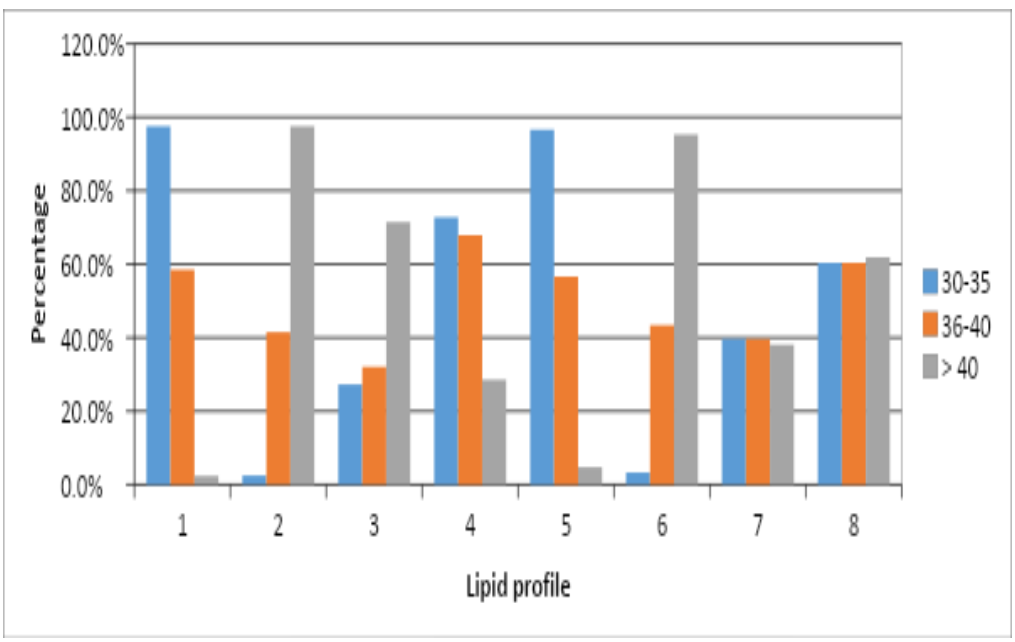

Figure 12:-Lipid profile and fatty liver in Obese patients (BMI> 30 Kg/ m^2)

Table 13:-Prevalence of COVID-19 patients among obese with BMI >30 Kg/ m^2

COVID illness	No. of cases	Percentage
COVID-19 positive	68	31.5%
COVID-19 negative	148	69.5%

In the present times of covid-19 pandemic, out of 216 cases, 68 cases (31.5%) covid-19 positive cases.

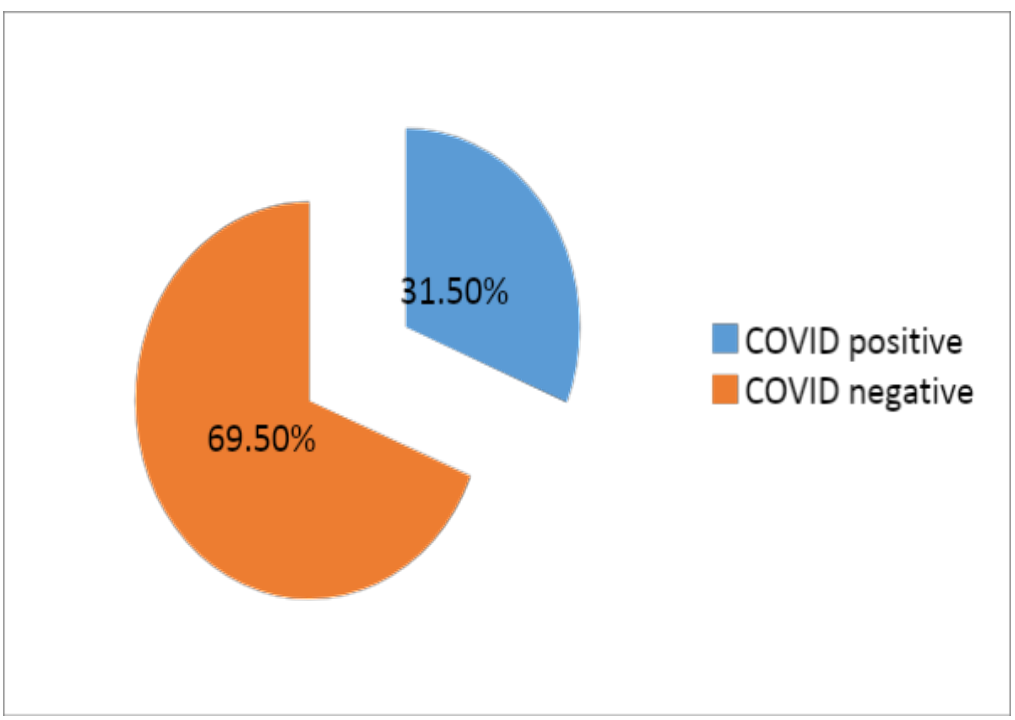

Figure 13:-Prevalence of COVID-19 patients among obese with BMI >30 Kg/ m^2

Table 14:-Distribution of obese patients with BMI >30 Kg/ m^2 as per predominant body system involved

System Predominantly Involved	No. of cases	Percentage
Respiratory	107	49.50%
Gastroenterology	21	9.70%
Neurological	16	7.40%
Genitourinary	43	19.90%
Cardiac	4	1.90%
Others	25	11.60%
Total	216	100.00%

In this study, 49.5% cases had predominantly respiratory system involvement, 19.9% had genitourinary system involvement, 9.7% had gastroenterology system involvement and 11.6% cases had other systems involved.

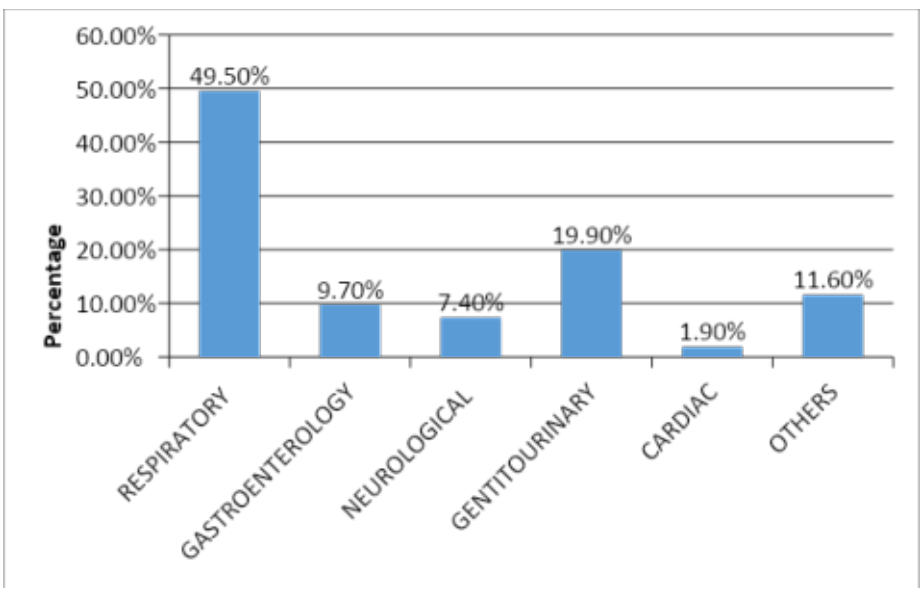

Figure 14:-Distribution of obese patients with BMI >30 Kg/ m^2 as per predominant body system involved

Table 15:- Hospital stay and BMI correlation in obese patients

HOSPITAL STAY	N	Mean	Std. Deviation	Chi-square	p-value
30-35	120	6.9	4.5		
36-40	53	9.4	6.0		
> 40	42	19.1	6.5		
Total	215	9.9	7.1	81.613	0.0001

As the BMI increases, patient becomes more morbid and have prolonged hospital stay. In our study it is statistically significant, patients with BMI >40kg/m2 had more hospital stay with std deviation of 7.1.

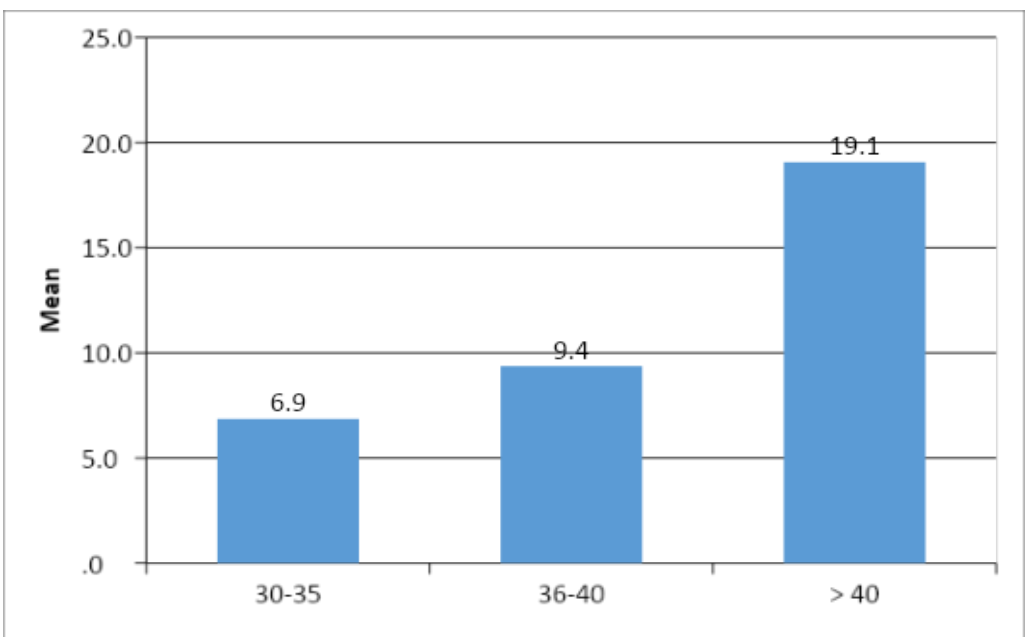

Figure 15:- Hospital stay and BMI correlation in obese patients

Table 16:- Mortality in obese (BMI >30 Kg/ m^2)patients as per dietary habits

		MORTALITY				Total	Chi-square value	p-value
		NO	NO	YES	YES			
DIETARY HABITS	Non-Veg	122	70.50%	23	53.50%	145	4.528	0.045
	Veg	51	29.50%	20	46.50%	71		
Total		173	100.00%	43	100.00%	216		

Out of 216 cases, there were 145 cases with non-vegetarian dietary habits, out of which 23 cases (53.50%) had mortality which was statistically significant

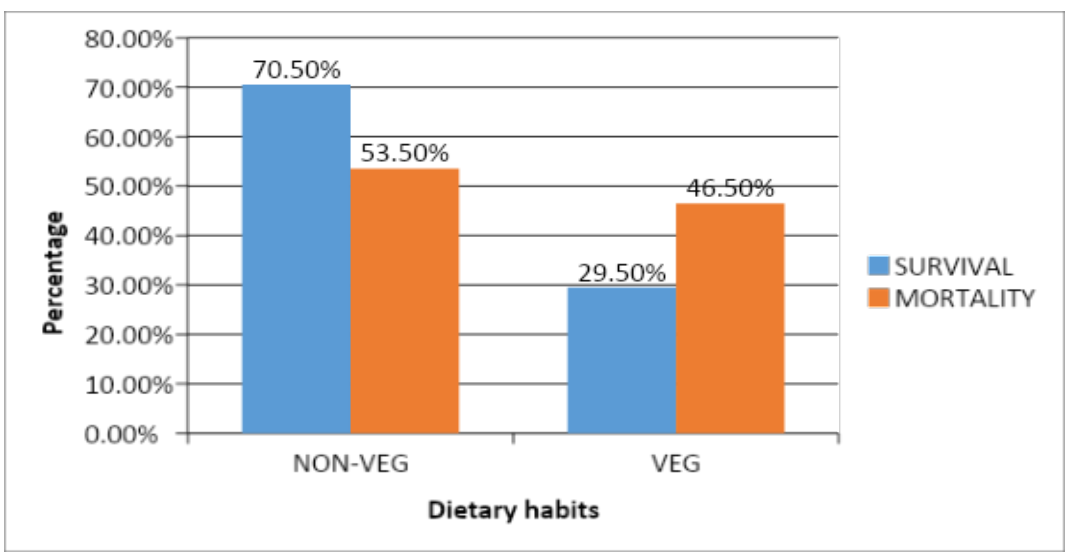

Figure 16: Mortality in obese (BMI >30 Kg/ m^2)patients as per dietary habits

Table 17:-Mortality in obese (BMI >30 Kg/ m^2) patients in relation to comorbidities

		MORTALITY						
	COMORBIDITY	**SURVIVAL**	**PERCENTAGE**	**MORTALITY**	**PERCENTAGE**	**TOTAL**	**CHI SQUARE**	**p-VALUE**
1	Type-II DM	139	80.3%	30	69.8%	169	2.26	0.132
2	HTN	121	69.9%	23	53.5%	144	41.96	0.048
3	HYPOTHYROID	11	6.4%	30	69.8%	41	90.043	0
4	OTHERS	36	20.8%	9	20.9%	45	0	0.986

Obese patients with hypertension had 23 cases (53.5%) with mortality which was statistically significant and similarly for hypothyroid patients (30 cases) 69.8% had mortality, which was statistically significant.

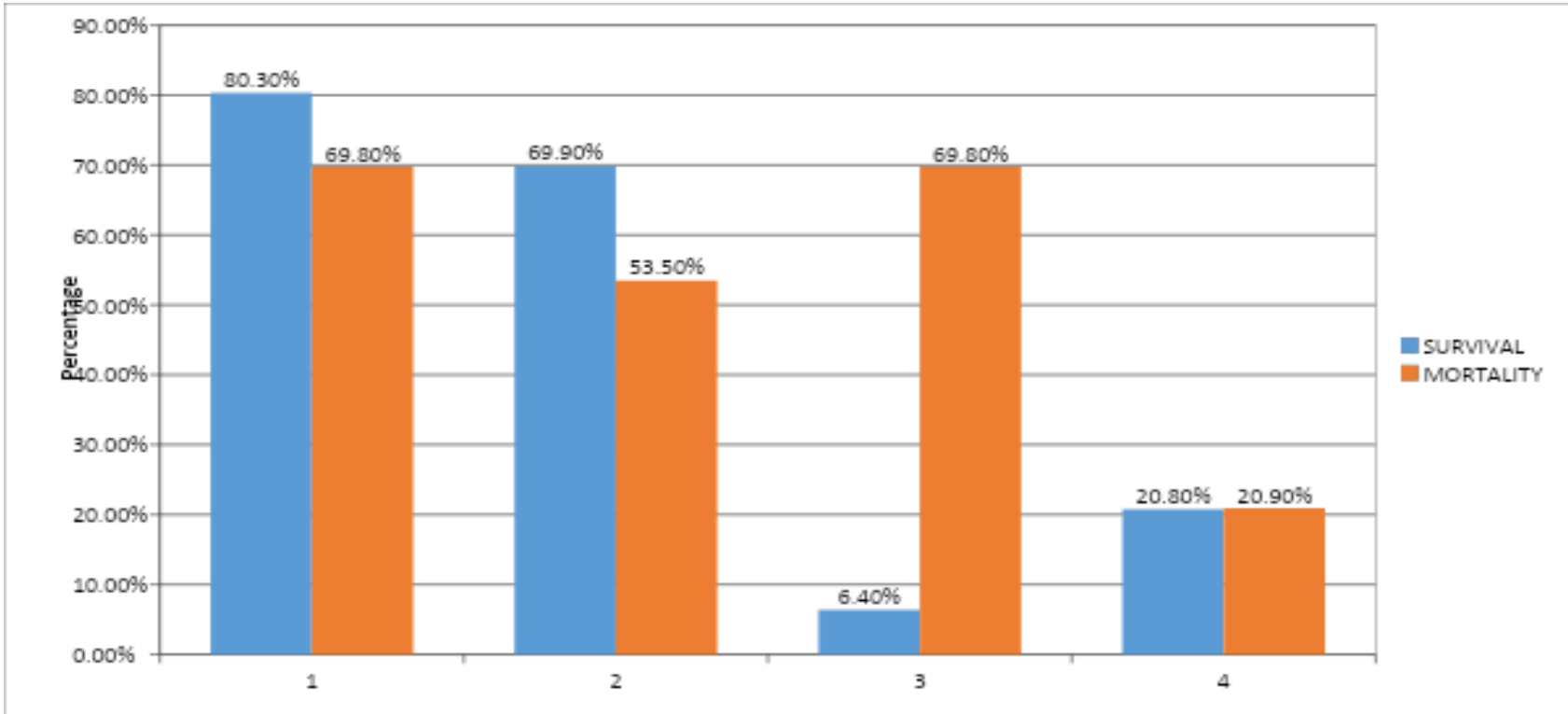

Figure 17: Mortality in obese (BMI >30 Kg/ m^2) patients in relation to co morbidities

Table 18:- Relationship of mortality and glycosylated haemoglobin in Obese patients (BMI> 30 Kg/ / m^2)

		MORTALITY				Total	Chi-square value	p-value
		SURVIVAL	PERCENTAGE	MORTALITY	PERCENTAGE			
HbA1c	5-6.0	24	13.90%	1	2.30%	25	60.321	0.0001
	6-8.0	67	38.70%	2	4.70%	69		
	8-10.0	45	26.00%	4	9.30%	49		
	> 10	37	21.40%	36	83.70%	73		

Obese patients with poor control of blood sugars, had more risk for mortality. Obese patients with glycosylated haemoglobin >10, had 36 cases (83.7%) having mortality which was statistically significant with p-value of 0.0001.

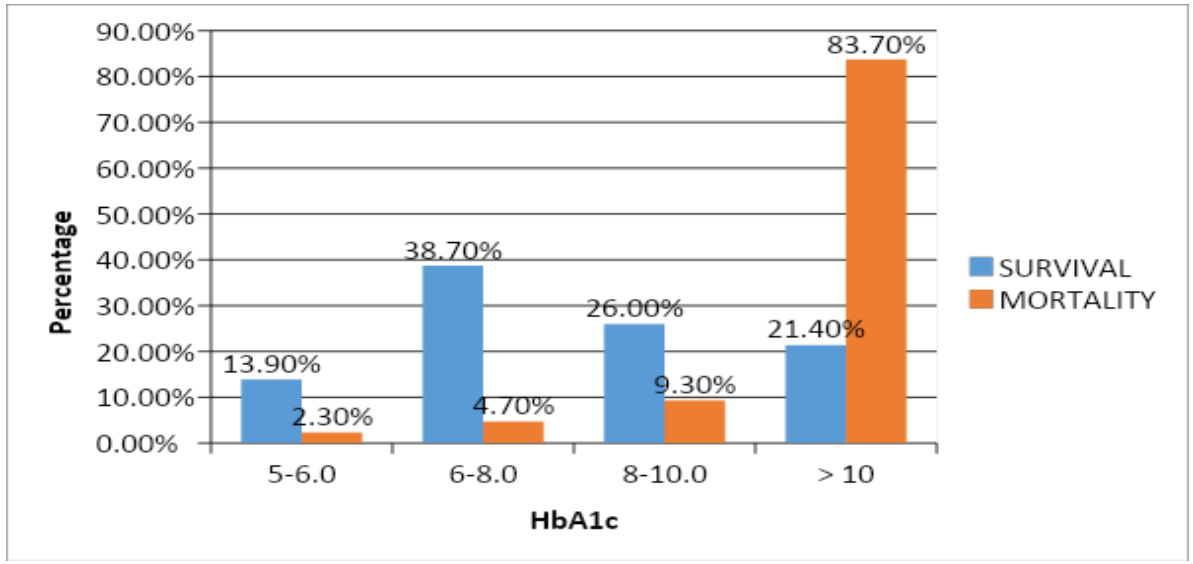

Figure 18: Relationship of mortality and glycosylated haemoglobin in Obese patients (BMI> 30 Kg/ m^2)

Table 19:- Relationship of mortality and OSA in Obese patients (BMI> 30 Kg/ m^2)

		MORTALITY				Total	Chi-square value	p-value
		NO	SURVIVAL	YES	SURVIVAL			
OSA	NO OSA	88	50.90%	4	9.30%	92	24.334	0.0001
	OSA	85	49.10%	39	90.70%	124		

Mortality in the presence of obesity and OSA was statistically significant. Cases with OSA had 90.70% mortality, with p value 0.0001.

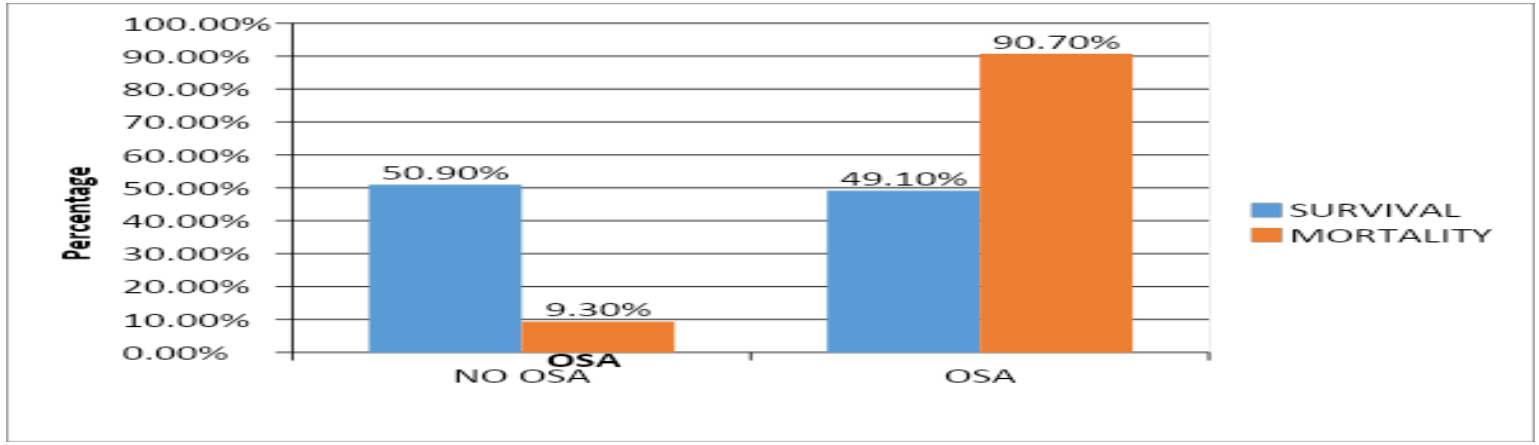

Figure 19: Relationship of mortality and OSA in Obese patients (BMI> 30 Kg/ m^2)

Table 20:- Relationship of mortality and waist hip ratio in Obese patients (BMI> 30 Kg/ m^2)

		MORTALITY				Total	Chi-square value	p-value
		SURVIVAL		MORTALITY				
WAIST HIP RATIO (>1.00 MALE/ >0.85 FEMALE)	WHR<1.00 M/ <0.85 F	36	20.80%	2	4.70%	38	6.202	0.013
	WHR>1.00M/>0.85F	137	79.20%	41	95.30%	178		
Total		173	100.00%	43	100.00%	216		

Patients with higher waist hip ratio, had higher risk for mortality, as charted in the table. 41 cases i.e. 95.30% had mortality was statistically significant with p-value 0.013.

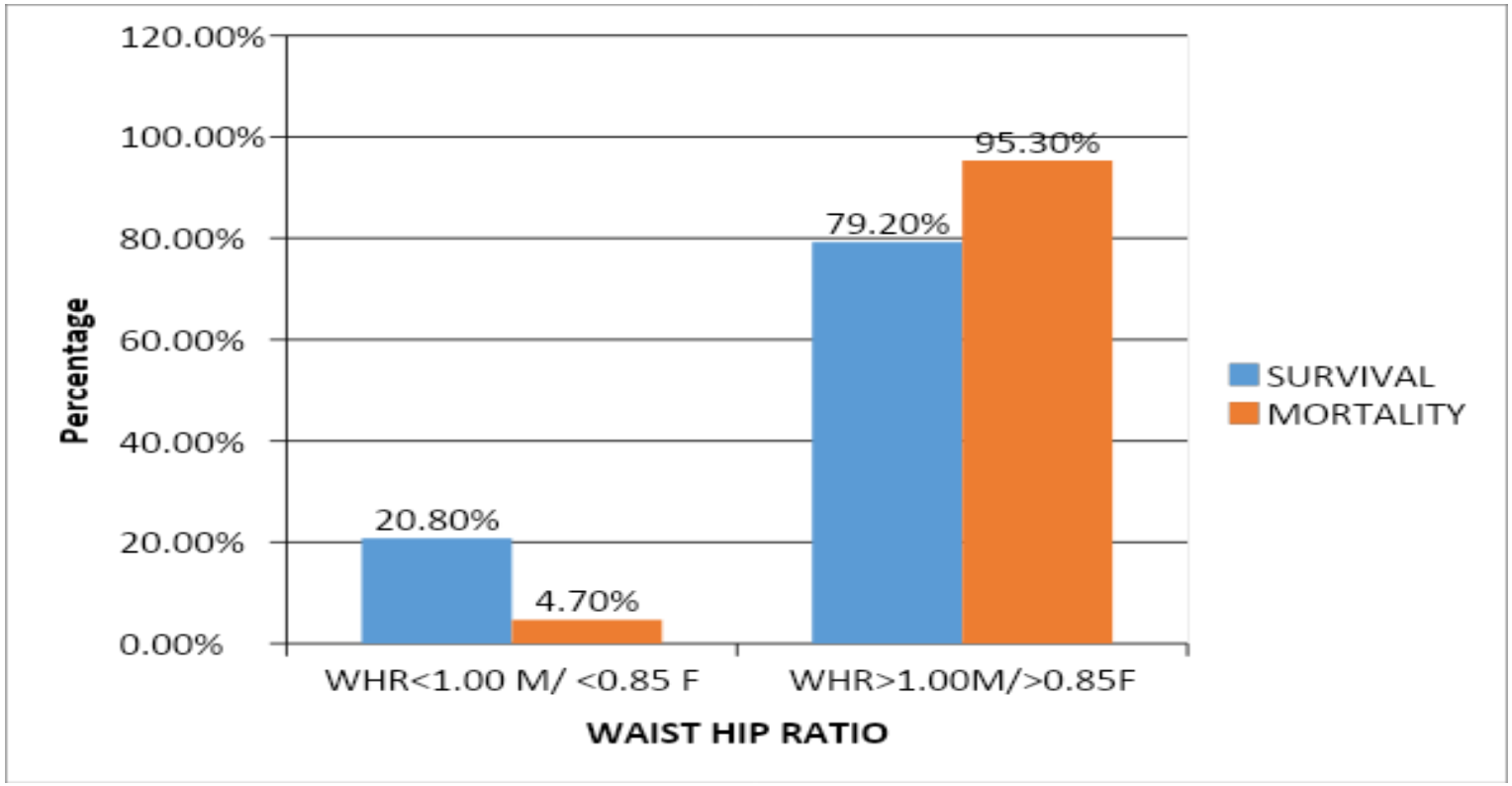

Figure 20: Relationship of mortality and waist hip ratio in Obese patients (BMI> 30 Kg/ m^2)

Table 21:- Relationship of mortality and deranged lipid profile and fatty liver in obese patients (BMI> 30 Kg/ m^2)

			MORTALITY				Total	Chi-square value	p-value
			SURVIVAL	PERCENTAGE	MORTALITY	PERCENTAGE			
LDL	1	LESS THAN 160	146	84.40%	4	9.30%	150	91.518	0
	2	MORE THAN 160	27	15.60%	39	90.70%	66		
HDL	3	LESS THAN 40	53	30.60%	27	62.80%	80	15.27	0
	4	MORE THAN 40	120	69.40%	16	37.20%	136		
TRIGLYCERIDES	5	LESS THAN 200	145	83.80%	4	9.30%	149	89.365	0
	6	MORE THAN 200	28	16.20%	39	90.70%	67		
FATTY LIVER	7	No fatty liver	69	39.90%	16	37.20%	85	0.103	0.748
	8	Fatty Liver	104	60.10%	27	62.80%	131		

With increasing BMI, and the presence of dyslipidaemia, there were more mortality cases. As seen in the table, cases with raised LDL, triglycerides and low HDL, had more mortality which was statistically significant with p-value of 0.

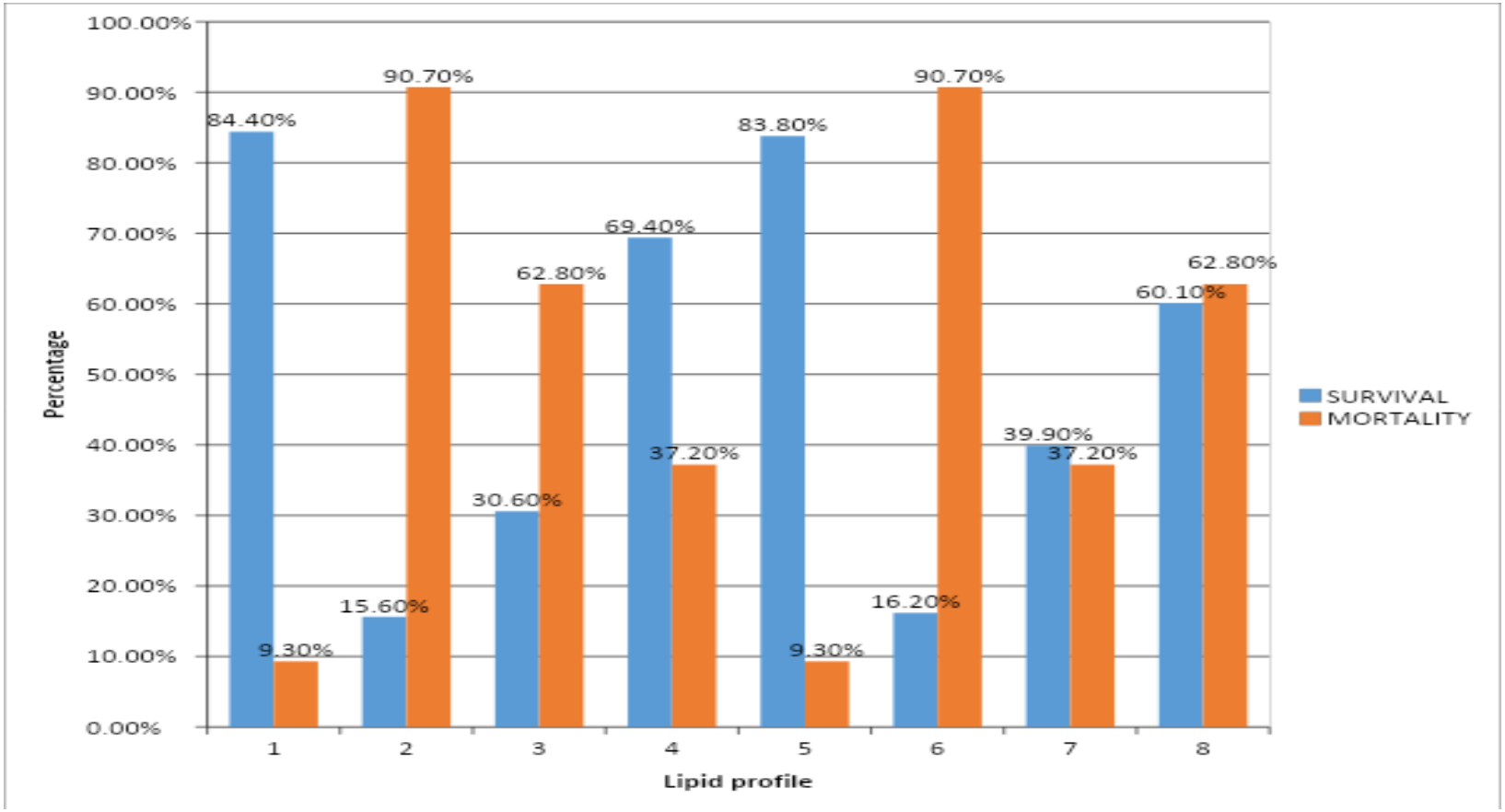

Figure 21: Relationship of mortality and deranged lipid profile and fatty liver in obese patients (BMI> 30 Kg/ m^2)

DISCUSSION

The epidemic of obesity is a major challenge to chronic disease prevention and health across the life course around the world. It is fueled by economic growth, industrialization, mechanized transport, urbanization, an increasingly sedentary lifestyle, and a nutritional transition to processed foods and high calorie diets over the last 30 years, many countries have witnessed the prevalence of obesity in its citizen's double and even quadruple.

'The clinical profile of obese patients', an observational study, which was conducted in obese patients admitted in tertiary care hospital, Dayanand Medical College and Hospital, Ludhiana. 216 subjects fulfilling the inclusion criteria were enrolled and studied for obesity related major clinical issues. The subjects were BMI >30Kg/ m^2 with age >18 years of age, excluding those who were pregnant or had ascites.

In a reference study, by Kanter R and et al,[112] it was found that Gender also plays a role, with women being disproportionately affected by extreme obesity (classes 2–3, BMI ≥35 kg/m^2) than men, regardless of age or race/ethnicity. Contrary to the study mentioned above, our study showed that there were 46.3% females & 53.7% males prevalence out of 216 cases enrolled.

The proportion of population out of 216 cases, the age group <30 years in BMI 30-35 kg/m^2 were (12 cases, 9.9%); BMI >40 kg/m^2 were (1 case, 2.4%). 30-50 years with BMI 30-35 kg/m^2 (22 cases, 18.2%); BMI >40 kg/m^2 were (9 cases, 21.4%) >50 years with BMI 30-35 kg/m^2 (87 cases; 71.9%); BMI >40 kg/m^2 were (32 cases; 76.2%). Maximum number of cases were found in age group >50 years. Similar population distributions were reported by Gopinath et al (114) and Zager et al[115] from Delhi and Kashmir valley respectively in their studies on obesity.

In this study it was observed that out of 216 subjects, BMI minimum was 30 with ranging up to maximum 48 BMI, with mean of 36.2 and standard deviation of 4.7. Swami et al [116] in their study among elderly

(>65 years) in Chandigarh, reported prevalence of overweight (BMI >25) and obesity (BMI >30) to be 33.14 % and 7.5 % respectively. Zager et al [115] in Kashmir valley adults and Sood et al [117] in Shimla town adults reported prevalence of obesity being 27.8% and 21.5% respectively.

There is a great environmental impact of the area, epidemiologically where the person lives. As the diet, physical activity, behavior and energy expenditure are affected by the surroundings. Neighborhood physical activity or recreational spaces has been associated with increased physical activity levels or energy expenditure. In this study, it was found that awareness regarding disease, healthy life style, easy availability of sports & gyms for exercise, dietician availability, proved that prevalence of obesity was almost comparable statistically in urban population (109 cases; 50.5%) and rural (107 cases;49.5%). There was a similar study done in urban and rural Rajasthan by Gupta et at [118] where prevalence of obesity was 11.4% and 5.2% in urban and rural area respectively.

In this study, it was found that as the BMI value increased, waist hip ratio was above normal range, in BMI range 30-35 kg/m2, 65.7% cases had waist hip ratio above normal range, but in BMI range 36-40 kg/m2 and above 40 kg/m2, 100% cases had waist hip ratio had above normal range i.e >1.00 in males and >0.85 in females. Kamboj et al[119] in their study found prevalence of central obesity to be (22.8%) and (29.9%) in males & females respectively.

Studies suggest that excess body weight may be protective against mortality from certain chronic conditions—resulting in a so-called “obesity paradox.” However, most studies that have shown an obesity paradox, or no association between obesity and mortality, have been conducted in groups of older (>65) or elderly patients or in those with chronic conditions, or have inadequately accounted for smoking. Indeed, the role of excess adiposity in old age is unclear. While the protective effects of overweight in specific instances of diseased older populations may be real, these observations are fraught with

methodological problems, especially reverse causation, and belie the limitations of generalizing excess adiposity's supposed benefits to younger populations over the life course, not least because excess body weight leads to higher disease incidence to begin with.

In this study, it was found that there is a linear correlation between the BMI and mortality. As seen in comparative study, 'Obesity in adulthood and its consequences for life expectancy: a life-table analysis' (120). As the BMI increases, the mortality increases, excess risk of total mortality, death from cardiovascular disease, diabetes, cancer, or accidental death, obesity in middle age shortens life expectancy by an estimated 4–7 years. In our study it was observed, that obese patients with co morbid conditions, had more mortality rate, which was statistically significant.

Obesity and Diabetes are closely linked. Obesity itself raises diabetes risk even in the absence of other metabolic dysregulation (insulin resistance, poor glycemic control, hypertension, dyslipidemia). In this study, it was found that 169 (78.9%) subjects out of 216, were Diabetic. As seen in comparative study, by Kissebah et al;[121] Obesity is a major predisposing factor for diabetes, the American Diabetes Association recommends physicians test for type 2 diabetes and assess risk of future diabetes in *asymptomatic* people ≥45 years old simply if they are overweight/obese, and regardless of age if they are severely obese, as observed in the article Standards of medical care in diabetes—2012. [122] Overweight raises risk of developing type 2 diabetes by a factor of three, and obesity by a factor of seven, compared to normal weight as observed in a meta-analysis of prospective cohort studies by Abdullah A et al. [123]

Obesity is a predisposing factor for dyslipidemia and hypertension, leading onto LV diastolic dysfunction. Cardiovascular risk factors and cardiac structural changes associated with obesity/overweight are also major determinants of LV diastolic function, as studied by Alpert MA et al.[124] In this study, it was found that (15 cases; 12.4% in BMI 30-35 kg/m^2 group and 6 patients, i.e. 14.3% in BMI >40 kg/m^2 group) obese

patients out of 216 subjects had diastolic dysfunction, which could be, a predictor of future development of heart failure. It was relatable to a study by Cesare Russo and et al,[125] which proved that the risk of diastolic dysfunction was significantly higher in overweight (adjusted odds ratio: 1.52, 95% confidence intervals 1.04–2.22) and obese (adjusted odds ratio: 1.60, 95% confidence intervals 1.06–2.41) compared to normal weight individuals. In our study, 20 cases (9.26%) had systolic dysfunction, as compared to study done by P Bloomstrand and et al,[126] Overweight and obesity were found to be associated with increased LV wall mass and the E/é ratio. Obesity leads to increased LV wall mass and the E/é ratio. Adiposity is associated with chronic volume overload resulting in increased peripheral vascular resistance. The Framingham Heart Study results indicated that obesity is associated with an increase in LV volume, wall thickness, and mass.

The dyslipidemia associated with obesity, plays a major role in the development of atherosclerosis and CVD in obese individuals. All of the components of the dyslipidemia, including higher triglycerides, decreased HDL levels, and increased small, dense LDL particles, have been shown to be atherogenic. As compared to study done by Kenneth R. Feingold and et al,[127] concluded that approximately 60-70% of patients with obesity are dyslipidemic. In our study, it was evident that as the BMI value increased, more the lipid profile was found abnormal in such patients, there were 2.5% (3 cases) with LDL >160 in patients with BMI range between 30-36 kg/m^2 ; (22 cases) % with BMI 36-40 kg/m^2 and 97.6% (41 cases) with BMI >40 kg/m^2 were having LDL >160. Similarly, number of cases with raised triglycerides were found more in the patients with BMI range >40 kg/m^2

Obesity and hypothyroidism are two common clinical conditions and have intriguing link between them; in our study it was found that out of 216 obese subjects, (41 cases; 19%) were hypothyroid. From a clinical perspective, obesity and mild thyroid failure are common diseases and frequently coexist. An Indian study showed that among the obese, 33% had overt, and 11% had subclinical hypothyroidism. It further showed

that obesity was more common (46% vs. 34%) in overt than in subclinical hypothyroidism, as discussed in study 'Hypothyroidism and obesity. Cause or effect?' By Verma et al.[128]

Obesity and hypertension. Excess body weight is a well-known risk factor for heart disease and ischemic stroke, including their typical antecedents—dyslipidemia and hypertension. In this study, out of 216 obese patients, 144 cases (66.7%) were hypertensive. The Framingham Study, Hazards of obesity--the Framingham experience, by Higgin et al, [129] also demonstrated that both men and women had an increase in blood pressure with increased overweight. Persons in the highest body mass index quartile had a 16 mmHg higher systolic blood pressure and a 9 mmHg higher diastolic blood pressure than persons in the lowest body mass index quartile. In this study, the systolic blood pressure increased 4 mmHg for each 4.5 kg of increased weight.

Obesity and dietary habits, in this study, it was observed that out of 216 subjects, (71 cases; 32.9%) vegetarian diet and (145 cases; 67.1%) having non-vegetarian diet predominantly, had more prevalence of obesity which was statistically significant. It was also observed, that obese patients consuming non vegetarian diet had more mortality rates (53.5%) than vegetarian ones (46.5%), which was statistically significant with p value of 0.045. In a comparative study, G Roman et al.,[130] identified 3 dietary patterns explaining 31.4% of the diet variation: High meat/High fat pattern, Western pattern and Prudent pattern. High meat/High fat pattern was associated with male gender, lower educational level, living in a rural, smoking and a higher probability for the presence of obesity (OR 1.2 [95%CI: 1.1-1.4]). Western pattern was associated with younger age, a higher level of physical activity and smoking. Prudent pattern was associated with older age, female gender, a higher level of physical activity, not smoking status and a lower probability for the presence of obesity (OR 0.8 [95%CI: 0.7-0.9]).

Obesity and covid-19 pandemic. In this study, it was observed that there is linear increase in risk of severe covid-19 infection leading to admission, hospitalization and mortality. Out of 216 enrolled subjects, (68 cases; 31.5%) were covid-19 positive and (16 patients; 37.2%) had mortality. As observed in, prospective cohort study by Min Gao et al, [131] 'Association of BMI and covid-19 severity.'

Obesity and fatty liver. There is an increased risk of nonalcoholic fatty liver disease (NAFLD) with obesity. It is seen that abnormalities in fatty acid metabolism, in conjunction with adipose tissue, hepatic, and systemic inflammation, are key factors involved in the development of insulin resistance, dyslipidemia and other cardio metabolic risk factors associated with NAFLD. The prevalence rate of NAFLD increases with increasing body mass index (BMI), as studied in, 'Obesity and Nonalcoholic Fatty Liver Disease: Biochemical, Metabolic and Clinical Implications' by Elisa Fabrrini.[132] In our study it was seen that, out of 216 obese patients, (131cases; 60.6%) had fatty liver evidence on ultrasonography.

Obesity predisposes to and potentiates OSA. Recent study by Abel Romero-Corral et al, [133] estimates that 60% of the adult population in industrialized countries is overweight (BMI ≥ 25 kg/m2) and at least 30% is obese (BMI ≥ 30 kg/m2). Similarly, it is noticed in this study, that out of 216 subjects, 29.8% cases in 30-35 kg/m2 group, 88.7% cases in 36-40kg/m2 group and 97.6% cases in >40kg/m2 group subjects had OSA evident.

There is a positive correlation between BMI with fasting serum glucose and glycosylated hemoglobin emphasizes the importance of maintenance of normal BMI to prevent early onset of type 2 diabetes mellitus. As studied by, RK Das et al (134), it was evident that both obese male and female persons showed higher levels of fasting serum glucose and glycosylated hemoglobin. In our study similarly it was seen, 88.1% cases in BMI >40kg/m2 range, had glycosylated hemoglobin >10, as the BMI values increase, more the glycosylated hemoglobin value is found deranged.

Patients with higher BMI, had higher prevalence of comorbidities. As observed in the study by Guh DP.[135] In our study similar correlation was seen, 78.2% of cases were found to be diabetic, 66.7% cases were hypertensive, 19% cases were hypertensive and 19% cases were hypothyroid.

BMI and mortality. In our study, it is observed that 43 cases (19.9%) had mortality. It is seen that as the BMI increases, the prevalence of co morbidities increased. Statistically significant data was found, patients with OSA had higher risk of mortality. Similarly, patients with raised glycosylated hemoglobin levels had significantly higher mortality. Also, patients with non-vegetarian dietary habits had more mortality (23 cases; 53.5%) as compared to patients with vegetarian dietary habits (20 cases, 46.5%). In similar study, 'Association of BMI with overall and cause-specific mortality: a population-based cohort study' by Bhaskaran K et al,[136] BMI is known to be strongly associated with all-cause mortality. BMI had J-shaped associations with overall mortality and most specific causes of death; for mental and behavioural, neurological, and external causes, lower BMI was associated with increased mortality risk.

BMI and hospital stay. Patients with high BMI values, were found to have more average stay in the hospital, as observed in our study, patients with BMI >40 had mean of 19.1 for hospital stay where as it was low for patients with BMI within range 30-35 being 6.9, these findings were statistically significant. As obesity adds on to the morbidity.

SUMMARY AND CONCLUSIONS

In study 'clinical profile of obese patients' it is concluded that obesity leads on to multiple health problems. Obesity in itself is not just a risk factor but a disease. The presence of obesity in a patient can change the course of the underlying disease and affect the outcome of the patient. In our study, it was found that patients with morbid obesity had prolonged stay in the hospital. We have studied correlation of obesity with various clinical parameters which can help to spread awareness and help clinician to have better decision making, which could help in improved patient care. From our study, it is concluded:-

- Obesity is more prevalent in urban population than rural
- Prevalence of obesity is more among males than in females
- Obesity is more prevalent in older age group i.e. age >50years
- Prevalence of hypertension, diabetes and hypothyroidism are higher among obese
- Waist hip ratio is a better predictor of obese related medical issues, patients with more waist hip ratio had higher mortality
- Obese patients tend to have poor blood sugar control and raised glycosylated hemoglobin levels
- Obesity and dietary habits impact each other. Patients with non-vegetarian diet had morbid obesity and higher risk for mortality
- Morbidly obese patients have OSA in statistically significant amount of cases. As the BMI increased, patients had more chances of OSA and hence higher risk of mortality
- Obesity impairs cardiac function, both systolic as well as diastolic
- Obese patients tend to have prolonged hospital stay, as obesity itself is a disease and adds to the morbidity of the patient
- Timely prevention of gaining excess weight can save many lives and avoid morbidity in many cases.

Recommendations

Prevention is better than cure. Prevention of obesity is easier, less expensive, more effective and safe than treating obesity after obesity has fully developed. Based on observation of the present study and review of literature, the following recommendations are made of obesity.

1. The promotion of healthy diets that are low in fat, high in complex carbohydrates and contain large amounts of fresh fruits and vegetables should be a made a routine in daily life.
2. Habit of skipping meals and snacking in between meals should be avoided.
3. Encourage physical activity. Community facilities and town planning policies should facilitate everyday walking and exercise by both adults and children.
4. After 40 years of age regular monitoring of blood pressure and blood sugar is required to detect co morbidities associated with obesity at the earliest possible.
5. Obesity prevention programmes should be more emphasized and stressed upon.
6. Obesity can be prevented or managed solely at individual level. Communities, governments, the media and the food industry need to work together to modify the environment so that it provides healthier food to eat and spread awareness for healthy lifestyle.

LIMITATIONS OF THE STUDY

Obesity was measured using only BMI, and no measurements of body fat distribution were made. A better relation might have been found between abdominal oesity and echocardiographic alterations. Investigation of cytokines, leptin, sympathetic nervous system activity, and renin–angiotensin–aldosterone system activity could have added information about the underlying mechanisms.

BIBLIOGRAPHY

1. Obesity and overweight https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.
2. World Health Organization. The world health report 2002: reducing risks, promoting healthy life. World Health Organization; 2002.
3. Gopalan C. Rising Incidence of Obesity, Coronary Heart Disease and Diabetes in the Indian Urban Middle Class. World Review of Nutrition and Fitness. 2001;90:127-43.
4. Ahirwar R, Mondal PR. Prevalence of obesity in India: A systematic review. Diabetes & Metabolic Syndrome: Clinical Research & Reviews. 2019;13:318-21.
5. Susser M, Stein Z. Timing in prenatal nutrition: a reprise of the Dutch Famine Study. Nutrition reviews. 1994;52:84-94.
6. Editor. Diabetes and obesity. https://www.diabetes.co.uk/diabetes-and-obesity.html
7. IUNS. The Global Challenge of Obesity and the International Obesity Task Force. international union of nutritional sciences. https://iuns.org/resources/the-global-challenge-of-obesity-and-the-international-obesity-task-force/
8. Prevalence of obesity. World Obesity Federation. https://www.worldobesity.org/about/about-obesity/prevalence-of-obesity
9. Keil U, Kuulasmaa K. WHO MONICA Project: risk factors. Int J Epidemiol 1989;18;46-55.
10 Overweight & obesity statistics. National Institute of Diabetes and Digestive and Kidney Diseases. https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity
11. Luhar S, Timæus IM, Jones R, Cunningham S, Patel SA, Kinra S, et al. Forecasting the prevalence of overweight and obesity in India to 2040. PloS one. 2020 ;15:e0229438.
12. Dhurandhar NV, Kulkarni PR. Prevalence of obesity in Bombay. Int

J Obes Relat Metab Disord 2022;16:367–75.

13. https://www.researchgate.net/publication/12053735 Prevalence of Obesity in Adults
14. Wander G, Khurana S, Gulati R, Sachar R, Gupta R. Epidemiology coronary heart disease in a rural Punjab population-prevalence and relation. Indian Heart J. 1994;46:319-23.
15. Flegal KM, Carroll MD, Kuczmarski RJ, Johnson CL. Overweight and obesity in the United States: prevalence and trends, 1960–1994. International journal of obesity. 1998;22:39-47.
16. Reilly JJ, Dorosty AR. Epidemic of obesity in UK children. The Lancet. 1999 27;354:1874-5.
17. Koplan JP, Dietz WH. Caloric imbalance and public health policy. Jama. 1999 27;282:1579-81.
18. Reilly JJ, Methven E, McDowell ZC, Hacking B, Alexander D et al. Health consequences of obesity. Archives of disease in childhood. 2003;88:748-52.
19. Whitelaw AG. Influence of maternal obesity on subcutaneous fat in the newborn. Br Med J. 1976;1:985-6.
20. Must A, Strauss RS. Risks and consequences of childhood and adolescent obesity. International journal of obesity. 1999;23:S2-11.
21. Dietz WH. Health consequences of obesity in youth: childhood predictors of adult disease. Pediatrics. 1998;101:518-25.
22. Gortmaker SL, Must A, Perrin JM, Sobol AM, Dietz WH. Social and economic consequences of overweight in adolescence and young adulthood. New England journal of medicine. 1993;329:1008-12.
23. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. New England journal of medicine. 1997 25;337:869-73.
24. Parsons TJ, Power C, Logan S, Summerbelt CD. Childhood predictors of adult obesity: a systematic review. International journal of obesity. 1999;23.
25. Dietz WH, Bellizzi MC. Introduction: the use of body mass index to

assess obesity in children. The American journal of clinical nutrition. 1999;70:123S-5S.

26. Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. Bmj. 2000;320:1240.
27. Elizabeth KE, Muraleedharan M. Three-in-One Weight, Height and Body Mass Index Charts for Children and Adults. Journal of tropical pediatrics. 2003;49:224-7.
28. Status WP. The use and interpretation of anthropometry: report of a World Health Organization (WHO) expert committee. Geneva, Switzerland: World Health Organization. 1995.
29. Nuttall FQ. Body mass index: obesity, BMI, and health: a critical review. Nutrition today. 2015;50:117.
30. Norgan NG. Body mass index and body energy stores in developing countries. European journal of clinical nutrition. 1990;44:79-84.
31. Han TS, Seidell JC, Currall JE, Morrison CE, Deurenberg P, Lean ME. The influences of height and age on waist circumference as an index of adiposity in adults. International journal of obesity. 1997;21:83-90.
32. Lean ME, Han TS, Morrison CE. Waist circumference as a measure for indicating need for weight management. Bmj. 1995;311:158-61.
33. http://apps.who.int/iris/bitstream/handle/10665/44583/9789241501491_eng.pdf?sequence=1
34. Pouliot MC, Després JP, Lemieux S, Moorjani S, Bouchard C, Tremblay A, et al. Waist circumference and abdominal sagittal diameter: best simple anthropometric indexes of abdominal visceral adipose tissue accumulation and related cardiovascular risk in men and women. The American journal of cardiology. 1994;73:460-8.
35. Ross RO, Leger L, Morris DA, de Guise JA, Guardo R. Quantification of adipose tissue by MRI: relationship with anthropometric variables. Journal of applied physiology. 1992 ;72:787-95.

36. Gadekar T, Dudeja P, Basu I, Vashisht S, Mukherji S. Correlation of visceral body fat with waist–hip ratio, waist circumference and body mass index in healthy adults: A cross sectional study. medical journal armed forces india. 2020;76:41-6.
37. Lean ME, Han TS, Deurenberg P. Predicting body composition by densitometry from simple anthropometric measurements. The American journal of clinical nutrition. 1996 ;63:4-14.
38. Han TS, Richmond P, Avenell A, Lean ME. Waist circumference reduction and cardiovascular benefits during weight loss in women. International journal of obesity. 1997;21:127-34.
39. Kuk JL, Janiszewski PM, Ross R. Body mass index and hip and thigh circumferences are negatively associated with visceral adipose tissue after control for waist circumference. The American journal of clinical nutrition. 2007;85:1540-4.
40. Slentz CA, Houmard JA, Kraus WE. Exercise, abdominal obesity, skeletal muscle, and metabolic risk: evidence for a dose response. Obesity. 2009;17:S27-33.
41. World Health Organization. Obesity: preventing and managing the global epidemic.
42. Hruby A, Hu FB. The epidemiology of obesity: a big picture. Pharmacoeconomics. 2015;33:673-89.
43. Drummond S, Crombie N, Kirk T. A critique of the effects of snacking on body weight status. European journal of clinical nutrition. 1996;50:779-83.
44. Holt S, Brand J, Soveny C, Hansky J. Relationship of satiety to postprandial glycaemic, insulin and cholecystokinin responses. Appetite. 1992;18:129-41.
45. Nestle M, Jacobson MF. Halting the obesity epidemic: a public health policy approach. Public health reports. 2000;115:12.
46. Rising R, Harper IT, Fontvielle AM, Ferraro RT, Spraul M, Ravussin E. Determinants of total daily energy expenditure: variability in physical activity. The American journal of clinical nutrition.

1994;59:800-4.

47. Schulz LO, Schoeller DA. A compilation of total daily energy expenditures and body weights in healthy adults. The American journal of clinical nutrition. 1994;60:676-81.
48. Davies PS, Gregory J, White A. Physical activity and body fatness in pre-school children. International journal of obesity and related metabolic disorders: journal of the International Association for the Study of Obesity. 1995;19:6-10.
49. Westerterp KR, Goran MI. Relationship between physical activity related energy expenditure and body composition: a gender difference. International journal of obesity. 1997;21:184-8.
50. Prentice AM, Jebb SA. Obesity in Britain: gluttony or sloth?. Bmj. 1995 ;311:437-9.
51. Allison DB, Faith MS, Nathan JS. Risch's lambda values for human obesity. International journal of obesity and related metabolic disorders: journal of the International Association for the Study of Obesity. 1996;20:990-9.
52. Krishnasamy K, Raghuramulu N, Nair KM, Brahmam GN, Ranganathan S, Vijayaraghavan K, et al. Animal models of obesity & their usefulness in molecular approach to obesity. Indian J Med Res. 1998;108.
53. Das UN, Meguid MM. Nutrition, physical activity, and obesity. The Lancet. 2002 19;360:1249-50.
54. Das UN. Is obesity an inflammatory condition?. Nutrition. 2001;17:953-66.
55. Gopalan C. Obesity in the Indian urban'middle class'. NFI bulletin. 1998;19:1-4.
56. Hulshof KF, Löwik MR, Kok FJ, Wedel M, Brants HA, Hermus RJ, et al. Diet and other life-style factors in high and low socio-economic groups (Dutch Nutrition Surveillance System). European journal of clinical nutrition. 1991;45:441-50.
57. Armstrong J, Reilly JJ. Breastfeeding and lowering the risk of

childhood obesity. The Lancet. 2002;359:2003-4.

58. Troisi RJ, Heinold JW, Vokonas PS, Weiss ST. Cigarette smoking, dietary intake, and physical activity: effects on body fat distribution—the Normative Aging Study. The American journal of clinical nutrition. 1991;53:1104-11.
59. Dallosso HM, James WP. The role of smoking in the regulation of energy balance. International journal of obesity. 1984;8:365-75.
60. Jitnarin N, Kosulwat V, Rojroongwasinkul N, Boonpraderm A, Haddock CK, Poston WS. The relationship between smoking, body weight, body mass index, and dietary intake among Thai adults: results of the national Thai food consumption survey. Asia Pacific Journal of Public Health. 2014;26:481-93.
61. Williamson DF, Madans J, Anda RF, Kleinman JC, Giovino GA, Byers T. Smoking cessation and severity of weight gain in a national cohort. New England Journal of Medicine. 1991;324:739-45.
62. Salvestrini V, Sell C, Lorenzini A. Obesity may accelerate the aging process. Frontiers in endocrinology. 2019;10:266.
63. Health risks Obesity Prevention Source. https://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/
64. Owolabi EO, Ter Goon D, Adeniyi OV. Central obesity and normal-weight central obesity among adults attending healthcare facilities in Buffalo City Metropolitan Municipality, South Africa: a cross-sectional study. Journal of health, population and nutrition. 2017;36:1-0.
65. McKeigue PM. Metabolic consequences of obesity and body fat pattern: lessons from migrant studies. The origins and consequences of obesity. 1996:54-67.
66. Bobak M, Marmot M. East-West mortality divide and its potential explanations: proposed research agenda. Bmj. 1996;312:421-5.
67. Reddy KS, Yusuf S. Emerging epidemic of cardiovascular disease in developing countries. Circulation. 1998;97:596-601.

68. Nishtar S. Prevention of coronary heart disease in south Asia. The Lancet. 2002;360:1015-8.
69. Mann JI. Diet and risk of coronary heart disease and type 2 diabetes. The Lancet. 2002;360:783-9.
70. Enas EA, Mehta J. Malignant coronary artery disease in young Asian Indians: thoughts on pathogenesis, prevention, and therapy. Clinical cardiology. 1995;18:131-5.
71. Hubert HB, Feinleib M, McNamara PM, Castelli WP. Obesity as an independent risk factor for cardiovascular disease: a 26-year follow-up of participants in the Framingham Heart Study. Circulation. 1983;67:968-77.
72. Manson JE, Colditz GA, Stampfer MJ, Willett WC, Rosner B, Monson RR, et al. A prospective study of obesity and risk of coronary heart disease in women. New England journal of medicine. 1990;322:882-9.
73. Han TS, Van Leer EM, Seidell JC, Lean ME. Waist circumference action levels in the identification of cardiovascular risk factors: prevalence study in a random sample. Bmj. 1995;311:1401-5.
74. Brochu M, Poehlman ET, Ades PA. Obesity, body fat distribution, and coronary artery disease. Journal of Cardiopulmonary Rehabilitation and Prevention. 2000;20:96-108.
75. Bader DS, Maguire TE, Spahn CM, O'Malley CJ, Balady GJ. Clinical profile and outcomes of obese patients in cardiac rehabilitation stratified according to National Heart, Lung, and Blood Institute criteria. Journal of Cardiopulmonary Rehabilitation and Prevention. 2001;21:210-7.
76. Wildman RP, Mackey RH, Bostom A, Thompson T, Sutton-Tyrrell K. Measures of obesity are associated with vascular stiffness in young and older adults. Hypertension. 2003;42:468-73.
77. Stamler J, Neaton JD, Wentworth DN. Blood pressure (systolic and diastolic) and risk of fatal coronary heart disease. Hypertension. 1989:I2.

78. Stamler R, Stamler J, Riedlinger WF, Algera G, Roberts RH. Weight and blood pressure: findings in hypertension screening of 1 million Americans. Jama. 1978 ;240:1607-10.
79. Van Itallie TB. Health implications of overweight and obesity in the United States. Annals of internal medicine. 1985;103:983-8.
80. Pi-Sunyer FX. Health implications of obesity. The American journal of clinical nutrition. 1991;53:1595S-603S.
81. Burton BT, Foster WR. Health implications of obesity: an NIH Consensus Development Conference. Journal of the American Dietetic Association. 1985 ;85:1117-21.
82. Abbott RD, Behrens GR, Sharp DS, Rodriguez BL, Burchfiel CM, Ross GW, et al. Body mass index and thromboembolic stroke in nonsmoking men in older middle age. The Honolulu Heart Program. Stroke. 1994;25:2370-6.
83. Diabetes Increase - Yenra from: https://yenra.com/diabetes
84. Cunningham SA, Riosmena F, Wang J, Boyle JP, Rolka DB, Geiss LS. Decreases in diabetes-free life expectancy in the US and the role of obesity. Diabetes Care. 2011;34:2225-30.
85. Schmidt MI, Duncan BB, Canani LH, Karohl C, Chambless L. Association of waist-hip ratio with diabetes mellitus: strength and possible modifiers. Diabetes care. 1992;15:912-4.
86. Chou P, Liao MJ, Tsai ST. Associated risk factors of diabetes in Kin-Hu, Kinmen. Diabetes research and clinical practice. 1994;26:229-35.
87. Lundgren H, Bengtsson C, Blohme G, Lapidus L, Sjöström L. Adiposity and adipose tissue distribution in relation to incidence of diabetes in women: results from a prospective population study in Gothenburg, Sweden. International journal of obesity. 1989;13:413-23
88. Premanath M, Basavanagowdappa H, Mahesh M, Suresh M. Correlation of abdominal adiposity with components of metabolic syndrome, anthropometric parameters and Insulin resistance, in obese and non obese, diabetics and non diabetics: A cross

sectional observational study.(Mysore Visceral Adiposity in Diabetes Study). Indian journal of endocrinology and metabolism. 2014;18:676.

89. Feller S, Boeing H, Pischon T. Body mass index, waist circumference, and the risk of type 2 diabetes mellitus: implications for routine clinical practice. Deutsches Ärzteblatt international. 2010;107:470.
90. Schranz AG, Savona-Ventura C. Long-term significance of gestational carbohydrate intolerance: a longitudinal study. Experimental and clinical endocrinology & diabetes. 2002;110:219-22.
91. Helmrich SP, Ragland DR, Leung RW, Paffenbarger Jr RS. Physical activity and reduced occurrence of non-insulin-dependent diabetes mellitus. New England journal of medicine. 1991;325:147-52.
92. https://www.tribuneindia.com/2004/20040621/nation.htm.
93. Armstrong BK. Cancer epidemiology and prevention. Int J Epidemiol 2018;47:2097–8.
94. Bergström A, Pisani P, Tenet V, Wolk A, Adami HO. Overweight as an avoidable cause of cancer in Europe. International journal of cancer. 2001;91:421-30
95. Health implications of obesity. National Institutes of Health Consensus Development Conference Statement. Ann Intern Med. 1985;103:147–51.
96. Schapira DV, Clark RA, Wolff PA, Jarrett AR, Kumar NB, Aziz NM. Visceral obesity and breast cancer risk. Cancer. 1994;74:632-9.
97. Bingham SA, Luben R, Welch A, Wareham N, Khaw KT, Day N. Are imprecise methods obscuring a relation between fat and breast cancer?. The Lancet. 2003 ;362:212-4.
98. Stinton LM, Shaffer EA. Epidemiology of gallbladder disease: cholelithiasis and cancer. Gut and liver. 2012;6:172.
99. Wadden TA, Foster GD, Stunkard AJ, Linowitz JR. Dissatisfaction with weight and figure in obese girls: Discontent but not depression. International journal of obesity. 1989;13:89-97.

100. Bagnjuk J, König HH, Hajek A. Personality traits and obesity. International journal of environmental research and public health. 2019;16:2675.
101. Sullivan M, Karlsson J, Sjöström L, Backman L, Bengtsson C, Bouchard C, Dahlgren S, Jonsson E, Larsson B, Lindstedt S. Swedish obese subjects (SOS)--an intervention study of obesity. Baseline evaluation of health and psychosocial functioning in the first 1743 subjects examined. International journal of obesity and related metabolic disorders: journal of the International Association for the Study of Obesity. 1993;17:503-12.
102. Davis Ma, Neuhaus Jm, Ettinger Wh, Mueller Wh. Body fat distribution and osteoarthritis. American Journal of Epidemiology. 1990;132:701-7.
103. Roubenoff R, Klag MJ, Mead LA, Liang KY, Seidler AJ, Hochberg MC. Incidence and risk factors for gout in white men. Jama. 1991;266:3004-7.
104. Felson DT, Zhang Y, Anthony JM, Naimark A, Anderson JJ. Weight loss reduces the risk for symptomatic knee osteoarthritis in women: the Framingham Study. Annals of internal medicine. 1992;116:535-9.
105. Kissebah AH, Peiris AN. Biology of regional body fat distribution: relationship to non-insulin-dependent diabetes mellitus. Diabetes/metabolism reviews. 1989;5:83-109.
106. Seidell JC, Björntorp P, Sjöström L, Kvist H, Sannerstedt R. Visceral fat accumulation in men is positively associated with insulin, glucose, and C-peptide levels, but negatively with testosterone levels. Metabolism. 1990;39:897-901.
107. Vgontzas AN, Tan TL, Bixler EO, Martin LF, Shubert D, Kales A. Sleep apnea and sleep disruption in obese patients. Archives of internal medicine. 1994;154:1705-11.
108. Strollo Jr PJ, Rogers RM. Obstructive sleep apnea. New England Journal of Medicine. 1996;334:99-104.
109. https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf.
110. Greene J, Hibbard JH, Alvarez C, Overton V. Supporting patient

behavior change: approaches used by primary care clinicians whose patients have an increase in activation levels. The Annals of Family Medicine. 2016;14:148-54.

111. Fletcher SW, Buring JE, Goodman SN, Goodridge AG, Guthrie HA, Hagan DW, et al Methods for voluntary weight loss and control. Annals of internal medicine. 1992;116:942-9.

112. Kanter R, Caballero B. Global gender disparities in obesity: a review. Advances in nutrition. 2012;3:491-8.

113. Johanson RB, Rolfe P, Spencer SA, Rai R. Should thermometers be issued to birth attendants in Nepal?. Journal of tropical pediatrics. 1992;38:202.

114. Gopinath N, Chadha SL, Jain P, Shekhawat S, Tandon R. An epidemiological study of obesity in adults in the urban population of Delhi. The Journal of the Association of Physicians of India. 1994;42:212-5.

115. Zargar AH, Masoodi SR, Laway BA, Khan AK, Wani AI, Bashir MI, et al. Prevalence of obesity in adults--an epidemiological study from Kashmir Valley of Indian Subcontinent. The Journal of the Association of Physicians of India. 2000 ;48:1170-4.

116. Researchgate.net.: https://www.researchgate.net/publication

117. Sood K, Gupta K, Ahluwalia K, Dhadwal D, Sharma K, Sood K. An Epidemiological Study Of Obesity In Smimla Town. Indian journal of medical sciences. 1996;50:362-4

118. Gupta R. Dr. RAJEEV GUPTA . World-heart-federation.org.

119. http://loads/download%20(3).pdf

120. Peeters A, Barendregt JJ, Willekens F, Mackenbach JP, Mamun AA, Bonneux L, et al. the Netherlands Epidemiology and Demography Compression of Morbidity Research Group*. Obesity in adulthood and its consequences for life expectancy: a life-table analysis. Annals of internal medicine. 2003 ;138:24-32

121. Kissebah AH, Vydelingum N, Murray R, Evans DJ, Kalkhoff RK, Adams PW. Relation of body fat distribution to metabolic complications of obesity. The Journal of Clinical Endocrinology &

Metabolism. 1982;54:254-60.

122. American Diabetes Association. Standards of medical care in diabetes--2010. Diabetes.

123. Abdullah A, Peeters A, de Courten M, Stoelwinder J. The magnitude of association between overweight and obesity and the risk of diabetes: a meta-analysis of prospective cohort studies. Diabetes research and clinical practice. 2010;89:309-19.

124. Alpert MA, Lavie CJ, Agrawal H, Kumar A, Kumar SA. Cardiac effects of obesity: pathophysiologic, clinical, and prognostic consequences—a review. Journal of cardiopulmonary rehabilitation and prevention. 2016;36:1-1.

125. Russo C, Jin Z, Homma S, Rundek T, Elkind MS, Sacco RL, et al. Effect of obesity and overweight on left ventricular diastolic function: a community-based study in an elderly cohort. Journal of the American College of Cardiology. 2011 ;57:1368-74.

126. Blomstrand P, Sjöblom P, Nilsson M, Wijkman M, Engvall M, Länne T, et al. Overweight and obesity impair left ventricular systolic function as measured by left ventricular ejection fraction and global longitudinal strain. Cardiovascular diabetology. 2018;17:1-2.

127. Feingold KR. Obesity and Dyslipidemia. from: https://pubmed.ncbi.nlm.nih.gov/26247088/

128. Abhyuday V, Muthukrishnan J, Hari KVS K, Kirtikumar D M. Hypothyroidism and obesity. Cause or Effect?.

129. Higgins M, Kannel W, Garrison R, Pinsky J, Stokes Iii Jo. Hazards Of Obesity-The Framingham Experience. Acta Medica Scandinavica. 1987;222:23-36.

130. Roman G, Rusu A, Graur M, Creteanu G, Morosanu M, Radulian G et al. Dietary patterns and their association with obesity: A cross-sectional study. Acta Endocrinologica (Bucharest). 2019 ;15:86.

131. Gao M, Piernas C, Astbury NM, Hippisley-Cox J, O'Rahilly S, Aveyard P, et al. Associations between body-mass index and COVID-19 severity in 6· 9 million people in England: a prospective,

community-based, cohort study. The Lancet Diabetes & Endocrinology. 2021;9:350-9.

132. Fabbrini E, Sullivan S, Klein S. Obesity and nonalcoholic fatty liver disease: biochemical, metabolic, and clinical implications. Hepatology. 2010;51:679-89.
133. Romero-Corral A, Caples SM, Lopez-Jimenez F, Somers VK. Interactions between obesity and obstructive sleep apnea: implications for treatment. Chest. 2010;137:711-9.
134. Das RK, Nessa A, Hossain MA, Siddiqui NI, Hussain MA. Fasting serum glucose and glycosylated hemoglobin level in obesity. Mymensingh medical journal: MMJ. 2014;23:221-8.
135. Guh DP, Zhang W, Bansback N, Amarsi Z, Birmingham CL, Anis AH. The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. BMC public health. 2009;9:1-20.
136. Bhaskaran K, dos-Santos-Silva I, Leon DA, Douglas IJ, Smeeth L. Association of BMI with overall and cause-specific mortality: a population-based cohort study of 3· 6 million adults in the UK. The lancet Diabetes & endocrinology. 2018;6:944-53.

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PROFORMA

Sr. No.

NAME CR NO

AGE DOA

SEX DOD

ADDRESS

CHIEF COMPLAINTS

HISTORY OF PRESENTING ILLNESS

CO-MORBIDITIES--

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

DIETARY CONSULT-

GENERAL EXAMINATION

VITALS

BP

HR

HEIGHT

WEIGHT

BMI

WAIST HIP RATIO

SYSTEMIC EXAMINATION

CNS--

CVS—

RESPIRATORY--

ABDOMEN--

DIAGNOSIS

SIGNATURE OF CANDIDATE

SIGNATURE OF SUPERVISOR

INVESTIGATIONS (As per done)

TEST	DATE	DATE
Hb		
TLC/DLC/PLT		
HCT		
LFT		
RFT		
USG		
RBS		
LIPID PROFILE		
THROID PROFILE		
ECG		
ECHO		
BNP		
SLEEP STUDY		
HbA1c		
OTHERS		

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						CNS
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	
				URBAN	RURAL				30-35	35-40	>40																	
1	KR	62 YRS	FEMALE	NO	YES	887599	07-Jan	17-Jan		37.1		YES	NO	NO	10	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
2	HK	50 YRS	MALE	YES	NO	884723	21-Jan	28-Jan	33.2			no	YES	NO	7	YES	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
3	KS	30 YRS	MALE	YES	NO	776583	25-Jan	01-Feb	32.9			no	YES	NO	8	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
4	SK	72 YRS	FEMALE	NO	YES	724002	26-Jan	11-Feb			46	no	NO	YES	15	NO	YES	YES	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
5	VB	72 YRS	MALE	NO	YES	889336	29-Jan	31-Jan	33.9			YES	NO	NO	3	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
6	SD	60 YRS	FEMALE	YES	NO	891356	03-Feb	13-Feb	33.9			YES	NO	NO	10	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
7	U	66 YRS	FEMALE	NO	YES	893148	05-Feb	25-Feb			46	YES	NO	NO	20	YES	YES	YES	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
8	NR	65 YRS	FEMALE	YES	NO	886560	07-Feb	14-Feb		37.1		YES	NO	NO	8	YES	NO	YES	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
9	GS	55 YRS	MALE	YES	NO	895640	09-Feb	18-Feb		35		YES	NO	NO	10	NO	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
10	SS	35 YRS	MALE	YES	NO	896950	11-Feb	28-Feb			45.9	YES	NO	NO	18	NO	YES	YES	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
11	JC	70 YRS	MALE	YES	NO	897045	11-Feb	25-Feb		36.7		YES	NO	NO	15	NO	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
12	JS	58 YRS	MALE	NO	YES	897875	12-Feb	21-Feb	33.1			YES	NO	NO	10	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
13	AD	52 YRS	FEMALE	YES	NO	873485	13-Feb	10-Mar		37		YES	NO	NO	25	YES	NO	YES	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
14	MK	62 YRS	FEMALE	YES	NO	898368	13-Feb	22-Feb	33.9			YES	NO	NO	10	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
15	SR	57 YRS	FEMALE	NO	YES	898540	14-Feb	17-Feb	30.3			no	YES	NO	4	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
16	JS	68 YRS	MALE	NO	YES	93280	15-Feb	21-Feb		36.6		YES	NO	NO	7	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
17	RK	60 YRS	FEMALE	YES	NO	900007	16-Feb	23-Feb		38		YES	NO	NO	8	NO	NO	NO	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
18	SD	75 YRS	FEMALE	NO	YES	193902	17-Feb	07-Mar			40.3	YES	NO	NO	18	YES	YES	YES	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
19	NG	62 YRS	FEMALE	NO	YES	232157	21-Feb	03-Mar	33.5			YES	NO	NO	10	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
20	SK	64 YRS	FEMALE	YES	NO	907884	28-Feb	20-Mar	34.2			no	YES	YES	20	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
21	SB	63 YRS	FEMALE	NO	YES	899208	28-Feb	20-Mar			40.8	YES	NO	NO	20	YES	YES	YES	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
22	VJ	62 YRS	FEMALE	NO	YES	903127	21-Mar	25-Mar	32.6			no	YES	NO	4	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
23	VR	55 YRS	FEMALE	NO	YES	920346	25-Mar	03-Apr		37		YES	NO	NO	9	NO	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
24	KR	57 YRS	FEMALE	YES	NO	268515	03-Apr	12-Apr	32.4			no	NO	YES	9	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
25	ML	54 YRS	MALE	NO	YES	5253	06-Apr	09-Apr	32.5			no	YES	NO	4	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.7	15.8	2.6	1.39	144	NO	YES	NO	YES	NO	YES	TSH-3.1	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	148	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	16.6	21.6	3	1.46	212	YES	NO	YES	NO	YES	NO	TSH-2.17	NO	YES	NORMAL SINUS RHYTM	YES	NO	YES	81	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.3	17	2.39	2.3	98	YES	NO	YES	NO	YES	NO	TSH-4.18	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	13	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.8	6.1	2.6	0.77	126	NO	YES	NO	YES	NO	YES	TSH-11	NO	YES	SINUS TACHYCARDIAS1Q3T3	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.9	11.5	1.9	0.85	216	YES	NO	YES	NO	YES	NO	TSH-0.5	YES	NO	NORMAL SINUS RHYTM	YES	NO	YES	18	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.5	8.3	3.5	1.18	277	YES	NO	YES	NO	YES	NO	TSH--0.7	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	251	NO	NO	YES	NO	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.3	9.7	2.4	0.95	300	NO	YES	NO	YES	NO	YES	TSH-14	NO	YES	SINUS TACHYCARDIA	YES	NO	NO	198	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.6	27.2	4.34	1.03	170	NO	YES	NO	YES	NO	YES	TSH-12	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	244	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.6	4.3	2.4	0.79	88	YES	NO	YES	NO	YES	NO	TSH-4.18	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	18	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.2	9.8	3.7	0.9	108	NO	YES	NO	YES	NO	YES	TSH-12	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	17	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.4	11.7	2.04	2.12	105	YES	NO	YES	NO	YES	NO	TSH-4.2	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.3	14	2.4	1.48	109	YES	NO	YES	NO	YES	NO	TSH-4.2	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.1	16.7	2.6	1.32	111	YES	NO	YES	NO	YES	NO	TSH-10	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	98	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.3	5.9	2.5	8.2	148	YES	NO	YES	NO	YES	NO	TSH-3	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	100	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.4	10.3	3.1	1.38	204	YES	NO	YES	NO	YES	NO	TSH-2	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	238	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.3	8.3	2.4	1.44	222	YES	NO	YES	NO	NO	YES	TSH--0.971	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	333	NO	YES	NO	NO	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.1	9	2.1	1.5	204	NO	YES	NO	YES	NO	YES	TSH-2.8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.2	6.2	2.5	1.7	102	NO	YES	NO	YES	YES	YES	TSH-10	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	1680	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.9	4	2	0.9	232	NO	NO	NO	NO	YES	NO	TSH-0.6	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	68	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.1	10.8	3.82	1.38	218	YES	NO	YES	NO	YES	NO	TSH-2.48	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	61.8	NO	YES	NO	NO	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.5	5.4	2.69	3.4	101	NO	YES	NO	YES	NO	YES	TSH-12	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.4	10.3	2.4	277	228	YES	NO	YES	NO	YES	NO	TSH-3.07	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	>5000	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.4	8.3	2.6	0.5	101	YES	NO	YES	NO	NO	YES	TSH-2	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	120	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.6	17	2.5	4.9	228	YES	NO	YES	NO	NO	YES	TSH-1.78	NO	YES	SINUS TACHYCARDIA	YES	NO	NO	495	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.8	5.9	2.2	1.06	200	YES	NO	YES	NO	NO	YES	TSH-3	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
NO	NO	YES	37.1	95	5'3"	YES	NO	110/70	84	YES	NO	NO	NO	NO	NO
NO	YES	NO	33.2	105	5'10"	YES	NO	120/80	72	NO	NO	YES	NO	NO	NO
NO	YES	NO	32.9	110	6'0	YES	NO	130/80	108	NO	NO	NO	NO	NO	YES
NO	YES	NO	46	120	5'3"	YES	NO	110/70	88	YES	NO	NO	NO	NO	NO
NO	YES	YES	33.9	89	5'5"	YES	NO	110/70	108	YES	NO	NO	NO	NO	NO
NO	NO	YES	33.9	88	5'5"	YES	NO	110/70	80	YES	NO	NO	NO	NO	NO
NO	YES	YES	46	115	5'3"	YES	NO	110/70	88	NO	NO	NO	NO	NO	YES
NO	YES	YES	37.1	105	5'4"	YES	NO	130/80	90	YES	NO	NO	NO	NO	NO
NO	YES	YES	35	97	5'3"	YES	NO	110/70	74	YES	NO	NO	NO	NO	NO
NO	NO	YES	45.9	133	5'11"	YES	NO	110/70	98	NO	NO	NO	YES	NO	NO
NO	YES	YES	36.7	94	5'3"	YES	NO	118/70	98	YES	NO	NO	NO	NO	NO
NO	YES	YES	33.1	96	5'7"	YES	NO	110/70	84	YES	NO	NO	NO	NO	NO
NO	NO	YES	37	95	5'3"	YES	NO	130/70	86	NO	NO	NO	YES	NO	NO
NO	YES	YES	33.9	84	5'2"	YES	NO	110/70	86	NO	NO	YES	NO	NO	NO
NO	YES	NO	30.3	88	5'4"	YES	NO	126/82	84	NO	NO	NO	YES	NO	NO
NO	NO	YES	36.6	110	5'7"	YES	NO	110/70	104	NO	YES	NO	NO	NO	NO
NO	NO	YES	38	100	5'8''	YES	NO	112/70	85	YES	NO	NO	NO	NO	NO
NO	YES	YES	40.3	100	5'2"	YES	NO	100/60	66	NO	NO	NO	NO	NO	NO
NO	YES	YES	33.5	86	5'3"	YES	NO	130/80	88	NO	NO	NO	YES	NO	NO
NO	NO	NO	34.2	82	5'2"	YES	NO	120/80	80	YES	NO	NO	NO	NO	NO
NO	NO	YES	40.8	125	5'9'	YES	NO	110/70	80	YES	NO	NO	NO	NO	NO
NO	NO	NO	32.6	75	5'2"	NO	YES	110/70	88	YES	NO	NO	NO	NO	NO
NO	NO	YES	37	95	5'3"	YES	NO	110/70	120	NO	NO	NO	YES	NO	NO
NO	NO	NO	32.4	75	5'	YES	NO	150/90	117	NO	NO	NO	NO	NO	YES
NO	YES	NO	32.5	90	5'8"	YES	NO	130/80	84	YES	NO	NO	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	CNS
				URBAN	RURAL				30-35	35-40	>40																	
26	SK	65 YRS	FEMALE	NO	YES	921652	09-Apr	17-Apr		37.9		YES	NO	NO	9	NO	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
27	JK	48 YRS	FEMALE	NO	YES	33979	10-Apr	13-Apr	33.2			no	YES	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
28	SK	55 YRS	FEMALE	NO	YES	41140	10-Apr	17-Apr		35.3		no	YES	NO	8	YES	YES	NO	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
29	CK	50 YRS	FEMALE	NO	YES	921890	10-Apr	18-Apr		37.4		YES	NO	NO	9	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
30	N	48 YRS	FEMALE	NO	YES	922064	12-Apr	13-Apr	33.7			no	NO	YES	2	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
31	MS	62 YRS	MALE	NO	YES	922476	15-Apr	03-May	30.9			no	YES	NO	18	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	DROWSY BUT AROUSABLE/ BILATERAL PLANTAR FLEXOR
32	SD	51 YRS	MALE	NO	YES	392419	16-May	30-May		38.1		YES	NO	NO	14	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
33	VK	60 YRS	MALE	NO	YES	922994	20-Apr	12-May			40.8	YES	NO	NO	22	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
34	RC	60 YRS	FEMALE	YES	NO	335472	21-Apr	09-May		35.4		YES	NO	NO	18	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
35	US	60 YRS	FEMALE	NO	YES	923689	25-Apr	04-May	31.2			no	YES	NO	9	YES	YES	YES	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
36	TK	60 YRS	FEMALE	NO	YES	293642	26-Apr	04-May	31.9			no	YES	NO	8	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
37	MK	65 YRS	FEMALE	NO	YES	924140	28-Apr	02-May	31.1			no	YES	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
38	RD	28 YRS	MALE	NO	YES	929049	25-May	27-May	30			no	YES	NO	3	NO	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
39	AK	73 YRS	FEMALE	NO	YES	928922	25-May	03-Apr	34.6			YES	NO	NO	10	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON, POWER RIGHT SIDE U/L L/L-3/5
40	RL	75 YRS	MALE	NO	YES	928789	24-May	25-May	31.3			YES	NO	NO	2	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	DROWSY BUT AROUSABLE/ BILATERAL PLANTAR FLEXOR
41	MS	52 YRS	MALE	YES	NO	929183	26-May	28-May	30			no	NO	YES	3	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
42	GS	60 YRS	MALE	YES	NO	929072	26-May	29-May	30			no	YES	NO	4	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
43	PK	60 YRS	FEMALE	YES	NO	864546	27-May	28-May	30.8			no	YES	NO	2	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
44	SK	68 YRS	FEMALE	NO	YES	929308	27-May	11-Jun			40.3	YES	NO	NO	15	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON, POWER RIGHT SIDE U/L L/L-3/5
45	AK	53 YRS	FEMALE	NO	YES	927968	28-May	08-Jun			43.5	YES	NO	NO	11	YES	NO	YES	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
46	HS	59 YRS	MALE	NO	YES	476274	28-May	07-Jun		37		no	YES	NO	10	NO	YES	YES	NO	NO	YES	NO	NO	NO	NO	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
47	KD	70 YRS	FEMALE	NO	YES	930448	30-May	06-Jun		38.8		YES	NO	NO	8	NO	NO	YES	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
48	PS	55 YRS	MALE	NO	YES	864428	03-Jun	25-Jun			47.4	YES	NO	NO	22	NO	YES	YES	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	10.8	1.96	0.49	112	NO	YES	NO	YES	YES	NO	TSH-1.02	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	44	YES	NO	NO	NO	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.1	14.3	2.8	1.3	330	YES	NO	YES	NO	YES	NO	TSH-1.78	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	98.6	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.1	10.6	2.4	0.78	222	YES	NO	YES	NO	YES	NO	TSH-1.02	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.6	25	3.37	0.86	105	NO	YES	NO	YES	NO	YES	TSH-0.95	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	111	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	13	2.9	0.87	300	YES	NO	YES	NO	YES	NO	TSH-3.23	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.7	9.2	2.4	1.52	208	YES	NO	YES	NO	YES	NO	TSH-0.95	YES	NO	ATRIAL FIBRILLATION	NO	NO	YES	255	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.6	12	2.6	1.06	205	NO	YES	NO	YES	NO	YES	TSH-1.03	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	118	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.2	10	2.4	1.8	98	NO	YES	NO	YES	NO	YES	TSH-1.14	NO	YES	ATRIAL FIBRILLATION	NO	NO	YES	1020	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.8	14	2.5	3.29	118	YES	NO	YES	NO	YES	NO	TSH-0.5	NO	YES	RBBB	NO	NO	YES	>5000	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.7	16	2.8	1.64	102	YES	NO	YES	NO	YES	NO	TSH-9	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	302	NO	NO	YES	NO	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.6	4	2.1	1.6	122	YES	NO	YES	NO	YES	NO	TSH-2	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.5	11	2.2	1.25	200	YES	NO	YES	NO	YES	NO	TSH-3.4	NO	YES	NSTEMI	NO	NO	YES	308	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	3.2	4.03	0.57	119	YES	NO	YES	NO	YES	NO	TSH-4.9	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	28	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	12	3.98	1.61	136	YES	NO	YES	NO	YES	NO	TSH-3	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.3	3	2.77	0.86	208	YES	NO	YES	NO	YES	NO	TSH-4.9	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	36	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	6.8	10	2.4	14	260	YES	NO	YES	NO	YES	NO	TSH-4.9	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	738	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	17	2.9	7.6	203	YES	NO	YES	NO	YES	NO	TSH-4.9	YES	NO	ATRIAL FIBRILLATION	NO	YES	NO	980	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.8	7.7	2.2	8.31	300	YES	NO	YES	NO	YES	NO	TSH-3.2	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	387	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.5	10	3.07	1.18	233	NO	YES	NO	YES	NO	YES	TSH-11	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	195	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.4	10.4	2.1	0.82	102	NO	YES	NO	YES	NO	YES	TSH-9	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	28	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.1	8.1	3.2	11.7	244	NO	YES	NO	YES	NO	YES	TSH-10	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	118	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.3	5	1.86	1.01	108	NO	YES	NO	YES	NO	YES	TSH-8	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	108	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	8.4	3.19	0.74	149	NO	YES	NO	YES	NO	YES	TSH-12	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
NO	NO	YES	37.9	90	154CM	YES	NO	120/80	80	YES	NO	NO	NO	NO	NO
NO	YES	NO	33.2	88	5'4"	YES	NO	110/70	88	NO	NO	NO	YES	NO	NO
NO	YES	NO	35.3	85	155 CM	YES	NO	130/80	90	NO	NO	NO	YES	NO	NO
NO	NO	YES	37.4	98	5'4"	YES	NO	100/60	104	NO	NO	YES	NO	NO	NO
NO	YES	NO	33.7	78	5'	YES	NO	140/80	90	NO	NO	YES	NO	NO	NO
NO	NO	NO	30.9	98	5'10"	YES	NO	100/60	98	NO	NO	NO	YES	NO	NO
NO	YES	YES	38.1	100	5'4"	YES	NO	110/70	84	NO	YES	NO	NO	NO	NO
NO	NO	YES	40.8	125	5'9"	YES	NO	130/80	85	YES	NO	NO	NO	NO	NO
NO	YES	YES	35.4	85	5'1"	YES	NO	130/80	90	YES	NO	NO	NO	NO	NO
NO	NO	NO	31.2	80	5'3"	YES	NO	130/80	102	YES	NO	NO	NO	NO	NO
NO	YES	NO	31.9	9	5'6"	NO	YES	110/60	88	NO	YES	NO	NO	NO	NO
NO	YES	NO	31.1	85	5'4"	NO	YES	110/70	88	NO	NO	NO	NO	YES	NO
NO	YES	NO	30	86	5'8"	NO	YES	110/60	92	NO	YES	NO	NO	NO	NO
NO	YES	YES	34.6	80	5'	YES	NO	140/80	118	NO	NO	YES	NO	NO	NO
NO	YES	YES	31.3	98	5'10"	YES	NO	130/90	92	NO	NO	YES	NO	NO	NO
NO	NO	NO	30	109	6'3"	NO	YES	130/90	84	NO	NO	NO	YES	NO	NO
NO	NO	NO	30	89	5'8"	NO	YES	150/90	108	NO	NO	NO	YES	NO	NO
NO	NO	NO	30.8	80	5'5"	NO	YES	140/90	104	NO	NO	NO	YES	NO	NO
NO	YES	YES	40.3	100	5'2"	YES	NO	120/70	80	NO	NO	YES	NO	NO	NO
NO	NO	YES	43.5	115	5'4"	YES	NO	110/70	88	NO	YES	NO	NO	NO	NO
NO	YES	NO	37	104	5'6"	YES	NO	140/90	102	NO	NO	NO	YES	NO	NO
NO	YES	YES	38.8	75	5'5"	YES	NO	130/90	100	YES	NO	NO	NO	NO	NO
NO	YES	YES	47.4	96	5'10"	YES	NO	120/70	80	NO	YES	NO	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						CNS
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	
				URBAN	RURAL				30-35	35-40	>40																	
49	AG	72 YRS	MALE	YES	NO	833012	03-Jun	17-Jun		35.4		YES	NO	NO	14	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
50	BK	72 YRS	MALE	NO	YES	931554	03-Jun	21-Jun		36.4		YES	NO	NO	18	YES	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
51	JK	52 YRS	FEMALE	NO	YES	930442	04-Jun	28-Jun	34.8			YES	NO	NO	24	NO	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
52	PS	65 YRS	MALE	NO	YES	931938	05-Jun	12-Jun	30			no	YES	NO	8	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; DROWSY BUT AROUSABLE
53	MS	23 YRS	MALE	NO	YES	680844	05-Jun	08-Jun	32			no	NO	YES	4	NO	NO	NO	YES	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
54	AB	44 YRS	FEMALE	NO	YES	931250	05-Jun	01-Jul			43.5	YES	NO	NO	26	NO	NO	YES	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
55	KS	70 YRS	MALE	NO	YES	834835	06-Jun	26-Jun			47.6	YES	NO	NO	20	YES	NO	YES	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
56	KD	72 YRS	FEMALE	NO	YES	932631	07-Jun	15-Jun	34.3			YES	NO	NO	9	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
57	RK	58 YRS	MALE	NO	YES	934668	07-Jun	12-Jun	32.3			no	YES	NO	6	YES	NO	NO	YES	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
58	SK	50 YRS	FEMALE	NO	YES	933195	09-Jun	28-Jun			41.1	YES	NO	NO	19	NO	YES	YES	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
59	BS	55 YRS	MALE	NO	YES	926854	12-Jun	15-Jun	33.1			no	NO	YES	3	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
60	SS	72 YRS	FEMALE	NO	YES	934647	14-Jun	22-Jun		37.1		YES	NO	NO	8	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
61	NR	57 YRS	FEMALE	NO	YES	427079	18-Jun	27-Jun		39.7		YES	NO	NO	9	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
62	RK	53 YRS	FEMALE	NO	YES	936086	19-Jun	13-Jul			44.4	YES	NO	NO	24	YES	YES	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
63	AG	50YRS	MALE	NO	YES	936279	20-Jun	24-Jun	32			no	YES	NO	5	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
64	R	68 YRS	FEMALE	NO	YES	937694	26-Jun	17-Jul			43.5	YES	NO	NO	21	YES	YES	YES	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
65	M	42YRS	FEMALE	NO	YES	938405	29-Jun	13-Jul		36.3		YES	NO	NO	14	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
66	SB	73YRS	MALE	NO	YES	83654	30-Jun	16-Jul		37.1		YES	NO	NO	16	NO	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
67	RS	66 YRS	MALE	NO	YES	948782	29-Jul	07-Aug	32.6			no	NO	YES	9	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
68	PK	40YRS	FEMALE	YES	NO	949191	30-Jul	15-Aug			47.6	YES	NO	NO	16	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
69	MS	38 YRS	MALE	YES	NO	949674	01-Aug	05-Aug	30.8			no	NO	YES	4	NO	NO	NO	YES	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
70	SS	34YRS	MALE	YES	NO	835645	02-Aug	18-Aug			42.3	YES	NO	NO	16	NO	NO	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
71	SU	55YRS	MALE	NO	YES	950128	02-Aug	28-Aug			43.5	YES	NO	NO	26	YES	YES	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
72	GS	30YRS	MALE	YES	NO	942624	03-Aug	10-Aug		39.7		YES	NO	NO	8	NO	NO	NO	YES	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
73	PD	58YRS	FEMALE	YES	NO	950933	04-Aug	26-Aug		38.4		YES	NO	NO	22	NO	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.5	9.7	4.09	0.44	219	NO	YES	NO	YES	NO	YES	TSH-1.01	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.3	21	3.52	0.64	150	NO	YES	NO	YES	NO	YES	TSH-1.04	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	121	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.2	7.2	3.95	0.56	108	YES	NO	YES	NO	YES	NO	TSH-3.82	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	80	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.8	11	3.57	1.79	134	YES	NO	YES	NO	YES	NO	TSH-3.5	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	105	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.5	12.5	4.73	0.83	112	YES	NO	YES	NO	YES	NO	TSH-3.6	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	7.4	2.47	0.58	108	NO	YES	YES	NO	NO	YES	TSH-9	YES	NO	SINUS TACHYCARDIA	NO	YES	NO	75	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.1	11	2.49	0.77	345	NO	YES	NO	YES	NO	YES	TSH-11	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	147	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.1	8.6	4.42	0.66	92	YES	NO	YES	NO	YES	NO	TSH-2.69	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	92	YES	NO	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.3	4.2	2.41	3.15	295	YES	NO	YES	NO	YES	NO	TSH-1.56	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	46	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.3	14	4.53	0.78	112	NO	YES	NO	YES	NO	YES	TSH-8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	248	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.5	12	2.44	2.4	284	YES	NO	YES	YES	YES	NO	TSH-1.08	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	208	NO	YES	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.6	6.6	3.07	0.47	98	NO	YES	YES	NO	NO	YES	TSH-1.01	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	165	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.6	11	2.11	2.94	318	NO	YES	YES	NO	NO	YES	TSH-1.02	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	139	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.4	12.4	3.23	0.54	323	NO	YES	YES	NO	NO	YES	TSH-7.4	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	72	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.3	7	2.28	0.63	112	YES	NO	NO	YES	YES	NO	TSH-5	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9	17	4.2	4.57	112	NO	YES	YES	NO	NO	YES	TSH-10	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.8	5.4	2.4	0.65	352	NO	YES	YES	YES	NO	YES	TSH-0.8	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	28	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.5	11	4.32	0.92	148	NO	YES	YES	NO	NO	YES	TSH-2	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	18	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.4	10.3	2.4	277	228	YES	NO	NO	YES	YES	NO	TSH-3.07	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	>5000	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	6	2.88	0.5	208	NO	YES	YES	NO	NO	YES	TSH-10	YES	NO	NORMAL SINUS RHYTHM	YES	NO	NO	<5	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.2	26	2.6	1.06	108	YES	NO	NO	YES	YES	NO	TSH-5	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	35	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	6	2.84	1.2	111	NO	YES	YES	NO	NO	YES	TSH-8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	100	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	4	3.16	0.8	170	NO	YES	YES	NO	NO	YES	TSH-6	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	10.4	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	17	1.76	4.36	94	NO	YES	YES	NO	NO	YES	TSH-2	YES	NO	SINUS TACHYCARDIA	NO	YES	NO	100	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	11	2.5	0.68	200	NO	YES	YES	NO	NO	YES	TSH-4	YES	NO	NORMAL SINUS RHYTHM	NO	YES	NO	<5	YES	NO	NO	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
NO	YES	YES	35.4	85	5'1"	YES	NO	130/90	82	NO	NO	YES	NO	NO	NO
NO	NO	YES	36.4	85	5'8"	YES	NO	130/70	65	NO	NO	NO	YES	NO	NO
NO	YES	YES	34.8	110	5'10"	YES	NO	130/90	90	NO	NO	YES	NO	NO	NO
NO	YES	NO	30	87	5'7"	YES	NO	120/70	80	NO	NO	YES	NO	NO	NO
NO	NO	NO	32	110	6'1"	YES	NO	130/70	108	NO	YES	NO	NO	NO	NO
NO	YES	YES	43.5	108	5'2"	YES	NO	110/70	130	NO	NO	NO	NO	NO	YES
NO	NO	YES	47.6	118	5'2"	YES	NO	130/80	110	NO	NO	NO	YES	NO	NO
NO	NO	YES	34.3	85	5'2"	YES	NO	110/70	88	NO	NO	NO	YES	NO	NO
NO	YES	NO	32.3	102	5'10"	YES	NO	110/70	86	YES	NO	NO	NO	NO	NO
NO	YES	YES	41.1	102	5'2"	YES	NO	130/70	112	NO	NO	YES	NO	NO	NO
NO	NO	NO	33.1	93	5'6"	NO	YES	130/80	96	NO	YES	NO	NO	NO	NO
NO	YES	YES	37.1	98	5'4"	YES	NO	130/80	78	YES	NO	NO	NO	NO	NO
NO	NO	YES	39.7	105	5'4"	YES	NO	120/72	114	NO	NO	NO	YES	NO	NO
NO	YES	YES	44.4	110	5'2"	YES	NO	130/70	88	YES	NO	NO	NO	NO	NO
NO	YES	NO	32	90	5'6"	NO	YES	110/70	88	NO	YES	NO	NO	NO	NO
NO	YES	YES	43.5	108	5'2"	YES	NO	140/80	90	NO	YES	NO	NO	NO	NO
NO	YES	YES	36.3	90	5'2"	YES	NO	140/90	88	NO	NO	YES	NO	NO	NO
NO	YES	YES	37.1	105	5'4"	YES	NO	130/70	95	NO	NO	YES	NO	NO	NO
NO	NO	NO	32.6	75	5'2"	YES	NO	110/70	88	NO	NO	NO	YES	NO	NO
NO	NO	YES	47.6	118	5'2"	YES	NO	120/84	92	NO	NO	NO	YES	NO	NO
NO	NO	NO	30.8	92	5'8"	NO	YES	110/70	108	NO	YES	NO	NO	NO	NO
NO	YES	YES	42.3	105	5'2"	YES	NO	110/70	84	NO	NO	NO	NO	NO	YES
NO	YES	YES	43.5	108	5'2"	YES	NO	150/90	80	NO	NO	NO	NO	NO	YES
NO	YES	YES	39.7	105	5'4"	YES	NO	90/60	72	NO	NO	NO	NO	YES	NO
NO	YES	YES	38.4	108	5'6"	YES	NO	140/70	106	NO	NO	YES	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	CNS
				URBAN	RURAL				30-35	35-40	>40																	
74	RS	62 YRS	MALE	NO	YES	846381	04-Aug	28-Aug		37.5		YES	NO	NO	28	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
75	MS	70YRS	MALE	YES	NO	950921	04-Aug	31-Aug			43.5	YES	NO	NO	27	NO	YES	YES	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
76	V	52 YRS	FEMALE	YES	NO	950252	04-Aug	07-Aug		36.3		YES	NO	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
77	JK	58 YRS	FEMALE	YES	NO	951346	05-Aug	09-Aug		37.1		YES	NO	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
78	RK	67 YRS	MALE	YES	NO	951407	06-Aug	09-Aug		36.7		YES	NO	NO	4	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
79	M	20YRS	FEMALE	YES	NO	951416	06-Aug	14-Aug			44.4	YES	NO	NO	9	NO	NO	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
80	SS	77 YRS	MALE	YES	NO	951691	06-Aug	14-Aug		36.3		YES	NO	NO	9	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
81	JK	70YRS	MALE	NO	YES	505893	07-Aug	11-Aug	33.5			YES	NO	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
82	AK	45 YRS	MALE	NO	YES	945030	19-Aug	24-Aug	30.8			no	YES	NO	6	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
83	ML	62 YRS	FEMALE	NO	YES	955061	26-Oct	29-Oct		37.1	37.1	YES	NO	NO	4	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
84	SA	71 YRS	FEMALE	NO	YES	981053	28-Oct	16-Nov			42.3	YES	NO	NO	19	YES	YES	YES	NO	NO	YES	NO	NO	NO	NO	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
85	JK	60 YRS	FEMALE	NO	YES	928754	30-Oct	04-Nov	33.5			YES	NO	NO	6	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
86	VR	62YRS	FEMALE	NO	YES	983150	03-Nov	06-Nov	30.8			no	YES	NO	4	YES	YES	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
87	RK	55 YRS	MALE	YES	NO	983239	04-Nov	04-Dec			47.6	YES	NO	NO	30	YES	YES	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
88	GS	22 YRS	MALE	YES	NO	985811	10-Nov	13-Nov	33.5			YES	NO	NO	4	NO	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
89	S	48 YRS	MALE	YES	NO	986950	11-Nov	19-Nov		36.7		YES	NO	NO	9	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
90	SR	63 YRS	FEMALE	YES	NO	986157	11-Nov	27-Nov	34.8			YES	NO	NO	16	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
91	RG	59YRS	FEMALE	YES	NO	988308	11-Nov	14-Nov		37.1		YES	NO	NO	4	NO	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
92	AS	62YRS	MALE	YES	NO	596952	11-Nov	28-Nov			44.4	YES	NO	NO	17	YES	YES	YES	YES	NO	YES	YES	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
93	U	52YRS	FEMALE	YES	NO	985802	12-Nov	18-Nov		36.7		YES	NO	NO	7	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
94	PS	70YRS	MALE	YES	NO	986613	12-Nov	21-Nov	34.4			YES	NO	NO	9	NO	YES	NO	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
95	PP	78 YRS	MALE	YES	NO	958058	12-Nov	14-Nov	30.8			no	YES	NO	3	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
96	BS	60YRS	MALE	YES	NO	218378	12-Nov	23-Nov	33.5			YES	NO	NO	8	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
97	NA	67 YRS	FEMALE	NO	YES	53283	12-Nov	01-Dec			47.6	YES	NO	NO	19	YES	YES	YES	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
98	SK	75 YRS	FEMALE	NO	YES	983246	12-Nov	15-Nov	34.8			YES	NO	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																							DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.1	8.2	2.6	0.86	215	NO	YES	YES	NO	NO	YES	TSH-0.99	YES	NO	NORMAL SINUS RHYTHM	NO	YES	NO	38	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.8	12	2.6	7.7	208	NO	YES	YES	NO	NO	YES	TSH-9	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	45.6	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	6	1.96	1.6	204	YES	NO	NO	YES	YES	NO	TSH-1.39	NO	YES	NORMAL SINUS RHYTHM	NO	YES	NO	20	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.2	14	2.4	1.67	112	NO	YES	YES	NO	NO	YES	TSH-3	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	56	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	11	2.4	1.6	200	YES	NO	NO	YES	YES	NO	TSH-2	YES	NO	INFERIOR WALL MI (ST-T CHANGES)	NO	YES	NO	60	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.5	3.2	2.78	1	88	NO	YES	YES	NO	NO	YES	TSH-8	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	30	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.8	4	2.4	1.5	225	YES	NO	NO	YES	YES	NO	TSH-3.2	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	88	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	16	2.5	1.19	229	YES	NO	NO	YES	YES	NO	TSH-2	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.4	6.5	2.4	1.05	108	YES	NO	NO	YES	YES	NO	TSH-2	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	300	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.4	14	2.4	2.09	330	NO	YES	YES	NO	NO	YES	TSH-0.22	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	4600	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.4	9.8	1.6	2.28	208	NO	YES	YES	NO	NO	YES	TSH-8	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.1	7.1	3.33	3.01	208	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	154	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	11	0.25	2.4	128	YES	NO	NO	YES	YES	NO	TSH--0.18	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	148	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	7	0.87	3.2	113	NO	YES	YES	NO	NO	YES	TSH-0.24	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	57	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.6	6	0.44	2.9	101	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	11	0.62	2.9	202	YES	NO	NO	YES	YES	NO	TSH-5	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	6.5	0.39	3.18	340	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.3	7	0.39	3.09	100	NO	YES	YES	NO	NO	YES	TSH-1.8	YES	NO	NORMAL SINUS RHYTHM	NO	YES	NO	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	12	0.8	3.2	228	NO	YES	YES	NO	NO	YES	TSH-8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	208	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.6	10.9	0.64	3.8	245	YES	NO	NO	YES	YES	NO	TSH-4.8	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	5	0.84	2.58	108	YES	NO	NO	YES	YES	NO	TSH-1.8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.2	11	1.17	2.8	108	YES	NO	NO	YES	YES	NO	TSH-2.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	134	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	4.4	1.1	4	208	YES	NO	NO	YES	YES	NO	TSH-2.4	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	118	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.9	11	2.5	2.3	195	NO	YES	YES	NO	NO	YES	TSH-7.4	NO	YES	AF WITH FVR	YES	NO	NO	113	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	8	0.07	3.4	235	YES	NO	NO	YES	YES	NO	TSH-4	NO	YES	NORMAL SINUS RHYTHM	YES	NO	NO	108	NO	YES	NO	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
NO	YES	YES	37.5	112	5'8"	YES	NO	130/70	84	NO	NO	YES	NO	NO	NO
NO	YES	YES	43.5	108	5'2"	YES	NO	140/70	84	NO	NO	NO	YES	NO	NO
NO	YES	YES	36.3	90	5'2"	YES	NO	130/90	90	NO	NO	NO	NO	NO	YES
NO	YES	YES	37.1	105	5'4"	YES	NO	140/70	85	NO	NO	NO	NO	NO	YES
NO	YES	YES	36.7	94	5'3"	YES	NO	130/70	91	NO	NO	NO	NO	YES	NO
NO	YES	YES	44.4	110	5'2"	YES	NO	110/70	84	NO	NO	NO	NO	NO	YES
NO	YES	YES	36.3	90	5'2"	YES	NO	140/7	101	NO	NO	NO	NO	NO	YES
NO	NO	YES	33.5	100	5'8"	YES	NO	140/70	88	NO	NO	NO	YES	NO	NO
NO	NO	NO	30.8	80	5'5"	NO	YES	130/90	85	NO	YES	NO	NO	NO	NO
NO	NO	YES	37.1	95	5'3"	YES	NO	150/70	92	NO	NO	NO	YES	NO	NO
NO	NO	YES	42.3	105	5'2"	YES	NO	140/90	90	NO	NO	NO	YES	NO	NO
NO	NO	YES	33.5	100	5'8"	YES	NO	130/70	101	NO	NO	NO	YES	NO	NO
NO	NO	NO	30.8	80	5'5"	NO	YES	150/70	105	YES	NO	NO	NO	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	130/70	84	YES	NO	NO	NO	NO	NO
NO	YES	YES	33.5	100	5'8"	NO	YES	120/85	78	YES	NO	NO	NO	NO	NO
NO	YES	YES	36.7	94	5'3"	YES	NO	130/70	89	NO	NO	NO	NO	NO	YES
NO	YES	YES	34.8	110	5'10"	YES	NO	150/70	83	NO	NO	NO	NO	NO	YES
YES	NO	YES	37.1	95	5'3"	YES	NO	140/90	93	YES	NO	NO	NO	NO	NO
YES	NO	YES	44.4	110	5'2"	YES	NO	140/70	63	YES	NO	NO	NO	NO	NO
YES	NO	YES	36.7	94	5'3"	YES	NO	150/70	72	YES	NO	NO	NO	NO	NO
NO	YES	YES	34.4	112	5'11"	YES	NO	140/60	97	NO	NO	NO	NO	NO	YES
YES	NO	NO	30.8	80	5'5"	YES	NO	130/70	99	YES	NO	NO	NO	NO	NO
NO	NO	YES	33.5	100	5'8"	YES	NO	130/70	73	NO	NO	NO	YES	NO	NO
NO	NO	YES	47.6	108	5'2"	YES	NO	150/90	75	NO	NO	NO	YES	NO	NO
YES	NO	YES	34.8	110	5'10"	YES	NO	160/80	90	YES	NO	NO	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	CNS
				URBAN	RURAL				30-35	35-40	>40																	
99	SL	56YRS	MALE	NO	YES	987325	13-Nov	06-Dec			42.3	YES	NO	NO	23	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
100	BS	50 YRS	MALE	NO	YES	986869	13-Nov	19-Dec			48.4	YES	NO	NO	36	YES	YES	YES	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
101	KG	74 YRS	MALE	NO	YES	986655	13-Nov	14-Nov		37.1		YES	NO	NO	2	YES	YES	NO	YES	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
102	P	58 YRS	FEMALE	NO	YES	987258	15-Nov	22-Nov		37.1		YES	NO	NO	8	NO	NO	YES	NO	YES	NO	YES	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
103	SK	70 YRS	MALE	YES	NO	987554	16-Nov	19-Nov	33.5			YES	NO	NO	4	YES	NO	NO	NO	NO	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
104	UR	63 YRS	FEMALE	YES	NO	987744	16-Nov	05-Dec			40.3	YES	NO	NO	19	YES	YES	YES	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
105	P	57 YRS	FEMALE	NO	YES	987786	16-Nov	04-Dec		35.4		YES	NO	NO	18	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
106	RD	78YRS	MALE	NO	YES	986455	17-Nov	04-Dec			44.4	YES	NO	NO	17	YES	NO	NO	NO	YES	NO	NO	YES	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
107	RK	56YRS	MALE	YES	NO	989232	18-Nov	27-Nov	33.5			YES	NO	NO	9	NO	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
108	RN	88 YRS	MALE	YES	NO	336751	18-Nov	24-Nov			42.3	YES	NO	NO	7	NO	YES	YES	YES	NO	YES	YES	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
109	A	54YRS	FEMALE	NO	YES	989685	18-Nov	23-Nov	33.5			YES	NO	NO	6	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
110	KD	72 YRS	FEMALE	YES	NO	990645	18-Nov	22-Nov		37.1		YES	NO	NO	5	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
111	JS	49 YRS	MALE	YES	NO	986393	18-Nov	06-Dec		36.9		YES	NO	NO	18	YES	YES	NO	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
112	TR	66 YRS	MALE	YES	NO	862101	18-Nov	22-Nov		37.1		YES	NO	NO	5	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
113	OPG	70 YRS	MALE	YES	NO	988618	18-Nov	03-Dec		35.4		YES	NO	NO	15	YES	YES	NO	YES	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
114	SS	65 YRS	MALE	NO	YES	987292	18-Nov	09-Dec			47.6	YES	NO	NO	21	NO	NO	YES	NO	YES	NO	YES	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
115	A	47 YRS	MALE	NO	YES	987217	18-Nov	10-Dec			48.4	YES	NO	NO	22	YES	YES	YES	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
116	NS	62YRS	MALE	NO	YES	985599	18-Nov	27-Nov	31.4			no	YES	NO	9	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
117	S	60 YRS	MALE	YES	NO	988253	19-Nov	28-Nov	32			no	YES	NO	10	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
118	MS	40 YRS	MALE	YES	NO	989218	19-Nov	24-Nov	33.2			no	YES	NO	6	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
119	VK	66YRS	MALE	NO	YES	983522	20-Nov	27-Nov	33.5			no	YES	NO	8	YES	YES	NO	NO	NO	YES	YES	YES	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
120	BS	56YRS	MALE	YES	NO	989945	21-Nov	25-Nov	34.2			YES	NO	NO	5	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
121	M	42 YRS	FEMALE	YES	NO	982701	22-Nov	01-Dec	31.7			no	YES	NO	9	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
122	DS	66 YRS	MALE	NO	YES	991673	25-Nov	29-Nov		37.1		YES	NO	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
123	JK	60 YRS	FEMALE	YES	NO	989947	30-Nov	04-Dec	33.5			no	YES	NO	6	YES	YES	NO	YES	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.4	10	1.2	3.08	123	NO	YES	YES	NO	NO	YES	TSH-3.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	128	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	19	2.9	2.2	112	NO	YES	YES	NO	NO	YES	TSH-10	NO	YES	SINUS TACHYCARDIA	NO	YES	NO	112	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7	11	1.6	2.29	466	YES	NO	NO	YES	YES	NO	TSH-3.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.3	11	0.53	3.8	124	YES	NO	NO	YES	YES	NO	TSH-7.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	108	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14	10	0.5	3.2	118	YES	NO	NO	YES	YES	NO	TSH-3.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	128	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.6	11.7	2.01	3.4	198	NO	YES	YES	NO	NO	YES	TSH-6	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.9	10.4	0.53	4.07	209	YES	NO	NO	YES	YES	NO	TSH-2	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14	12	0.6	2.6	245	NO	YES	YES	NO	NO	YES	TSH-3.26	YES	NO	NORMAL SINUS RHYTHM	YES	NO	NO	248	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.9	6.8	1.29	2.4	180	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.9	10	1.9	2.5	105	NO	YES	YES	NO	NO	YES	TSH-9	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	134	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.5	12	0.53	3.3	300	YES	NO	NO	YES	YES	NO	TSH-0.39	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	112	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.2	6.8	0.69	3.4	110	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	102	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	8.5	0.79	2.8	100	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	225	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.3	12.6	1.6	4.03	118	YES	NO	NO	YES	YES	NO	TSH-3.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	147	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.7	5	0.92	4.01	83	YES	NO	NO	YES	YES	NO	TSH-4	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	108	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.3	7	1.2	3.2	102	NO	YES	YES	NO	NO	YES	TSH-7.4	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.3	11	1.56	3.2	118	NO	YES	YES	NO	NO	YES	TSH-7.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	118	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.2	14	0.68	3.07	228	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.1	14	1.08	3.49	238	YES	NO	NO	YES	YES	NO	TSH-3.4	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	114	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.5	4	0.76	3.11	86	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.7	9.8	0.61	3.4	102	YES	NO	NO	YES	YES	NO	TSH-3.4	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	55	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.3	6	0.66	2.6	282	YES	NO	NO	YES	YES	NO	TSH-0.25	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	46	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.2	9	1.8	3	350	YES	NO	NO	YES	YES	NO	TSH-0.24	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	143	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	19	2.9	2.2	112	YES	NO	NO	YES	YES	NO	TSH-4.2	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	112	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10	19	1.8	3	350	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
YES	NO	YES	42.3	105	5'2"	YES	NO	130/90	84	YES	NO	NO	NO	NO	NO
NO	NO	YES	48.4	110	5'4"	YES	NO	140/90	63	NO	NO	NO	YES	NO	NO
NO	NO	YES	37.1	95	5'3"	YES	NO	110/70	84	YES	NO	NO	NO	NO	NO
YES	NO	YES	37.1	95	5'3"	YES	NO	120/85	65	YES	NO	NO	NO	NO	NO
YES	NO	YES	33.5	100	5'8"	YES	NO	120/90	95	YES	NO	NO	NO	NO	NO
YES	NO	YES	40.3	100	5'2"	YES	NO	100/60	94	YES	NO	NO	NO	NO	NO
NO	YES	YES	35.4	115	5'11"	YES	NO	130/70	78	NO	NO	YES	NO	NO	NO
YES	NO	YES	44.4	110	5'2"	YES	NO	140/70	105	YES	NO	NO	NO	NO	NO
YES	NO	YES	33.5	100	5'8"	YES	NO	130/70	110	YES	NO	NO	NO	NO	NO
YES	NO	YES	42.3	105	5'2"	YES	NO	140/90	108	YES	NO	NO	NO	NO	NO
YES	NO	YES	33.5	100	5'8"	NO	YES	140/70	102	YES	NO	NO	NO	NO	NO
NO	YES	YES	37.1	98	5'4"	YES	NO	150/70	98	YES	NO	NO	NO	NO	NO
NO	YES	YES	36.9	110	5'8"	YES	NO	140/60	92	YES	NO	NO	NO	NO	NO
NO	NO	YES	37.1	95	5'3"	YES	NO	130/70	95	NO	NO	NO	YES	NO	NO
NO	NO	YES	35.4	115	5'11"	YES	NO	130/70	81	NO	YES	NO	NO	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	150/90	65	YES	NO	NO	NO	NO	NO
YES	NO	YES	48.4	110	5'4"	YES	NO	160/80	78	YES	NO	NO	NO	NO	NO
YES	NO	NO	31.4	102	5'11"	YES	NO	130/90	73	YES	NO	NO	NO	NO	NO
YES	NO	NO	32	104	5'11"	NO	YES	140/90	97	YES	NO	NO	NO	NO	NO
NO	YES	NO	33.2	108	5'11"	NO	YES	110/70	84	NO	NO	NO	NO	NO	YES
YES	NO	NO	33.5	100	5'8"	NO	YES	120/85	85	YES	NO	NO	NO	NO	NO
YES	NO	YES	34.2	108	5'10"	YES	NO	120/90	81	YES	NO	NO	NO	NO	NO
NO	NO	NO	31.7	103	5'11"	NO	YES	100/60	76	YES	NO	NO	NO	NO	NO
NO	NO	YES	37.1	95	5'3"	YES	NO	130/70	79	NO	NO	NO	YES	NO	NO
NO	YES	NO	33.5	106	5'10"	YES	NO	140/70	85	YES	NO	NO	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						CNS
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	
				URBAN	RURAL				30-35	35-40	>40																	
124	ND	57 YRS	FEMALE	NO	YES	1003568	22-Dec	27-Dec		37.1		YES	NO	NO	6	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
125	JS	45YRS	MALE	NO	YES	1003077	22-Dec	25-Dec		36.9		YES	NO	NO	4	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
126	BK	57 YRS	FEMALE	YES	NO	1005427	27-Dec	03-Jan	30.7			no	YES	NO	7	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
127	MK	62 YRS	FEMALE	YES	NO	624747	03-Jan	07-Jan	33.5			YES	NO	NO		YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
128	SK	63 YRS	MALE	YES	NO	1009498	07-Jan	12-Jan	34.2			YES	NO	NO	6	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
129	IK	60YRS	FEMALE	YES	NO	1009478	07-Jan	13-Jan	32.9			no	YES	NO	7	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
130	TK	55 YRS	MALE	YES	NO	302902	09-Jan	13-Jan	32			no	YES	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
131	V	18 YRS	MALE	NO	YES	1011102	11-Jan	14-Jan		35.4		YES	NO	NO	4	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
132	TS	53YRS	MALE	YES	NO	1007424	11-Jan	11-Jan		37.1		YES	NO	NO	1	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
133	BD	55 YRS	FEMALE	YES	NO	1011971	12-Jan	31-Jan			44.4	YES	NO	NO	19	NO	NO	YES	YES	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
134	KR	81YRS	FEMALE	YES	NO	883654	15-Jan	18-Jan	32			no	NO	YES	4	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
135	GL	52 YRS	MALE	YES	NO	1017090	27-Jan	12-Feb			47.6	YES	NO	NO	16	YES	NO	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
136	IS	51 YRS	MALE	YES	NO	634506	28-Jan	05-Feb	33.5			no	YES	NO	9	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
137	HC	42 YRS	MALE	YES	NO	1019615	29-Jan	03-Feb	32.3			no	YES	NO	6	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
138	JS	50 YRS	MALE	YES	NO	1019554	29-Jan	08-Feb	34.2			YES	NO	NO	10	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
139	SS	45 YRS	FEMALE	YES	NO	1019910	30-Jan	02-Feb	32.9			YES	NO	NO	4	YES	NO	NO	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
140	KK	60YRS	FEMALE	YES	NO	1019210	30-Jan	04-Feb	30.7			no	YES	NO	6	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
141	SS	60YRS	MALE	NO	YES	109532	31-Jan	02-Feb	30.8			no	NO	YES	3	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
142	TS	44 YRS	FEMALE	YES	NO	936419	05-Feb	08-Feb	32.9			no	YES	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
143	VK	60YRS	MALE	YES	NO	382935	13-Feb	15-Mar			44.4	YES	NO	NO	30	YES	NO	NO	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
144	SR	56 YR	FEMALE	YES	NO	788186	15-Feb	20-Feb		37.1		no	YES	NO	6	YES	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
145	SR	50 YRS	FEMALE	YES	NO	1032142	21-Feb	09-Mar		35.4		YES	NO	NO	16	YES	YES	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
146	HK	68 YRS	FEMALE	YES	NO	418609	21-Feb	06-Mar	33.5			no	YES	NO	13	YES	YES	NO	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
147	KS	47 YRS	MALE	YES	NO	1032095	21-Feb	24-Feb	30.8			no	NO	YES	4	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
148	BD	90 YR	MALE	YES	NO	1032888	22-Feb	27-Feb	32			no	YES	NO	6	YES	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.2	18	0.9	2.4	242	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	7	0.42	2.4	245	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8	13	1.6	1.2	184	YES	NO	NO	YES	YES	NO	TSH-3.9	NO	YES	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.7	4.2	1.1	1.92	208	YES	NO	NO	YES	YES	NO	TSH--2	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	251	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.4	19	0.64	2.5	112	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.4	12	1.5	2.2	390	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	9	0.86	2.5	118	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.9	14	0.34	2.5	342	YES	NO	NO	YES	YES	NO	TSH-3.9	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	6.2	1.2	0.42	1.94	200	NO	YES	YES	NO	NO	YES	TSH--2	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.3	18	2.4	0.43	122	NO	YES	YES	NO	NO	YES	TSH-7.4	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.4	18	1.2		100	YES	NO	NO	YES	YES	NO	TSH 1.68	YES	NO	AF WITH FVR	NO	NO	YES	265	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.4	5.8	3.69	0.79	308	NO	YES	YES	NO	NO	YES	TSH-7	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.4	5.8	3.69	0.79	308	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.8	5.7	2.6	1.7	123	YES	NO	NO	YES	YES	NO	TSH--2.8	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	1100	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.7	8	3.74	1.2	208	YES	NO	NO	YES	YES	NO	TSH-0.7	YES	NO	NORMAL SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	12	2.6	1.2	298	YES	NO	NO	YES	YES	NO	TSH--2.8	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	8	2.4	1.4	202	YES	NO	NO	YES	YES	NO	TSH--2.8		NO	SINUS TACHYCARDIA	NO	NO	YES	100	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	12	1.7	0.5	245	YES	NO	NO	YES	YES	NO	TSH--2.9	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.6	10	2.4	0.82	300	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.3	12.9	1.96	1.1	208	NO	YES	YES	NO	NO	YES	TSH-4.3	YES	NO	LAD; SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.1	7.9	2.92	1.6	308	YES	NO	NO	NO	NO	NO	TSH-4	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	106	NO	NO	NO	YES	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.1	5.8	2.5	0.66	101	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.3	8.2	2.91	0.85	212	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	RBBB	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.3	7.8	2.2	0.71	222	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	194	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.3	10.8	2.54	1.4	112	YES	NO	NO	YES	YES	NO	TSH-1.28	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	180	NO	YES	NO	NO	NO	NO	YES

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
YES	NO	YES	37.1	98	5'4"	YES	NO	130/70	84	YES	NO	NO	NO	NO	NO
YES	NO	YES	36.9	110	5'8"	YES	NO	140/90	101	YES	NO	NO	NO	NO	NO
NO	YES	NO	30.7	100	5'11"	NO	YES	140/70	102	NO	NO	NO	NO	NO	YES
YES	NO	YES	33.5	100	5'8"	YES	NO	150/70	118	YES	NO	NO	NO	NO	NO
YES	NO	YES	34.2	108	5'10"	YES	NO	140/60	119	YES	NO	NO	NO	NO	NO
NO	NO	NO	32.9	104	5'10"	YES	NO	130/70	104	NO	NO	NO	YES	NO	NO
NO	YES	NO	32	104	5'11"	NO	YES	130/70	107	YES	NO	NO	NO	NO	NO
NO	YES	YES	35.4	115	5'11"	YES	NO	150/90	108	NO	NO	NO	NO	NO	YES
NO	YES	YES	37.1	95	5'3"	YES	NO	160/80	91	NO	NO	NO	NO	NO	YES
NO	YES	YES	44.4	110	5'2"	YES	NO	130/90	98	NO	NO	NO	NO	NO	YES
NO	NO	NO	32	104	5'11"	NO	YES	140/90	95	NO	NO	NO	YES	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	110/70	97	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.5	100	5'8"	YES	NO	120/85	92	YES	NO	NO	NO	NO	NO
NO	YES	NO	32.3	102	5'10"	YES	NO	120/90	94	NO	NO	NO	NO	NO	YES
YES	NO	YES	34.2	108	5'10"	YES	NO	100/60	86	YES	NO	NO	NO	NO	NO
YES	NO	YES	32.9	104	5'10"	YES	NO	130/70	84	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.7	100	5'11"	NO	YES	140/70	88	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.8	80	5'5"	NO	YES	130/70	97	YES	NO	NO	NO	NO	NO
YES	NO	NO	32.9	104	5'10"	NO	YES	130/70	98	YES	NO	NO	NO	NO	NO
YES	NO	YES	44.4	110	5'2"	YES	NO	130/70	94	YES	NO	NO	NO	NO	NO
NO	NO	NO	37.1	95	5'3"	YES	NO	150/90	66	NO	YES	NO	NO	NO	NO
YES	NO	YES	35.4	112	5'10"	YES	NO	160/80	75	YES	NO	NO	NO	NO	NO
NO	NO	NO	33.5	100	5'8"	YES	NO	130/90	74	NO	NO	NO	YES	NO	NO
NO	YES	NO	30.8	80	5'5"	NO	YES	140/90	84	NO	NO	NO	NO	NO	YES
NO	NO	NO	32	104	5'11"	NO	YES	110/70	87	NO	NO	NO	YES	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						CNS
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	
				URBAN	RURAL				30-35	35-40	>40																	
149	RS	52 YRS	MALE	NO	YES	1033395	23-Feb	24-Feb	32.9			no	YES	NO	2	YES	NO	NO	YES	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
150	NG	35 YRS	MALE	YES	NO	1033795	24-Feb	24-Feb	33.8			no	NO	YES	1	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
151	CK	60 YRS	FEMALE	YES	NO	1035569	26-Feb	13-Mar			47.6	YES	NO	NO	15	YES	YES	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
152	RK	52 YRS	FEMALE	YES	NO	1036078	27-Feb	03-Mar	33.2			no	YES	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
153	DU	47 YRS	MALE	YES	NO	1036290	28-Feb	26-Mar			40.2	YES	NO	NO	27	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
154	NB	25 YRS	MALE	YES	NO	1036333	28-Feb	08-Mar	30.8			no	YES	NO	9	NO	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
155	GS	76 YR	MALE	NO	YES	1032469	28-Feb	05-Mar		37.1		YES	NO	NO	6	YES	YES	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
156	RD	62 YRS	FEMALE	YES	NO	1036179	28-Feb	03-Mar		37.1		YES	NO	NO	4	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
157	KB	69 YRS	FEMALE	YES	NO	690722	28-Feb	04-Mar	34.5			no	YES	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
158	HK	75 YRS	FEMALE	YES	NO	1034826	01-Mar	02-Mar	32.2			no	YES	NO	2	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
159	MK	62 YRS	FEMALE	YES	NO	1034936	01-Mar	04-Mar	33.5			no	YES	NO	4	NO	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
160	SK	49 YRS	MALE	YES	NO	455200	01-Mar	07-Mar	31.7			no	YES	NO	7	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
161	RR	73 YRS	FEMALE	NO	YES	260736	02-Mar	07-Mar	33.5			no	YES	NO	6	YES	YES	NO	NO	NO	YES	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
162	HS	39 YR	MALE	YES	NO	1038656	02-Mar	05-Mar			40.2	YES	NO	NO	4	YES	NO	YES	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
163	HL	59 YR	MALE	YES	NO	1034683	02-Mar	07-Mar	33.5			no	YES	NO	6	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
164	A	25 YRS	MALE	YES	NO	1038247	02-Mar	06-Mar	31.7			no	NO	YES	5	NO	NO	NO	YES	YES	NO	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
165	PL	71 YRS	MALE	NO	YES	160565	03-Mar	09-Mar			44.4	YES	NO	NO	16	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
166	GR	58 YRS	FEMALE	YES	NO	1039980	04-Mar	09-Mar	33.5			no	YES	NO	6	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
167	RK	46 YR	MALE	YES	NO	1041887	05-Mar	08-Mar	33.5			no	YES	NO	4	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
168	PK	68 YRS	MALE	YES	NO	1042343	05-Mar	30-Mar			47.6	YES	NO	NO	25	YES	NO	YES	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
169	S	66 YRS	MALE	NO	YES	139084	05-Mar	24-Mar		36.9		YES	NO	NO	19	YES	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
170	LR	47 YRS	FEMALE	YES	NO	1042538	06-Mar	20-Mar	34.2			YES	NO	NO	14	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
171	GS	19 YRS	MALE	YES	NO	1043488	07-Mar	26-Mar	35.4			YES	NO	NO	19	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
172	S	22 YRS	MALE	NO	YES	1009363	07-Mar	15-Mar	34.2			no	YES	NO	9	NO	YES	NO	NO	NO	YES	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
173	GS	53YRS	MALE	YES	NO	1043773	07-Mar	07-Mar	31.7			no	YES	NO	1	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.7	5.5	2.6	0.49	124	YES	NO	NO	YES	YES	NO	TSH--1.19	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	108	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.9	15.4	3	0.9	230	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.7	16	2.01	1.6	118	NO	YES	YES	NO	NO	YES	TSH-8.6	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	108	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.6	7.5	3.76	0.7	118	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.1	4.6	2.6	0.97	112	NO	YES	YES	NO	NO	YES	TSH-4.9	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	100	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.3	5.4	3.77	0.72	91	YES	NO	NO	YES	YES	NO	TSH--2.8	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.7	12	2.3	2.2	246	NO	YES	YES	NO	NO	YES	TSH--2.8	NO	YES	LAD	NO	NO	YES	208	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.3	8.6	3.8	0.51	256	YES	NO	NO	YES	YES	NO	TSH--2.9	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.6	12.5	2.2	1.69	118	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTM	NO	YES	NO	100	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.9	9.7	3.5	0.77	208	YES	NO	NO	YES	YES	NO	TSH-4.3	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	3.8	2.96	0.48	180	YES	NO	NO	YES	YES	NO	TSH-2.28	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	8	2.2	0.56	305	YES	NO	NO	YES	YES	NO	TSH-5.4	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	100	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.9	11	2.9	1.6	108	YES	NO	NO	YES	YES	NO	TSH--3.88	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.3	8.7	2.66	0.61	200	NO	YES	YES	NO	NO	YES	TSH-8	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	13.6	3.3	0.87	302	YES	NO	NO	YES	YES	NO	TSH--2.8	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.3	11.5	2.4	0.82	100	YES	NO	NO	YES	YES	NO	TSH--2.8	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.1	15	2.7	1.6	822	NO	YES	YES	NO	NO	YES	TSH--2.9	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	320	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.5	15	2.96	0.96	294	YES	NO	NO	YES	YES	NO	TSH-0.58	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.8	11.5	2.1	0.57	224	YES	NO	NO	YES	YES	NO	TSH--1.30	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.1	18	2.6	1	248	NO	YES	YES	NO	NO	YES	TSH-10	NO	YES	NORMAL SINUS RHYTM	YES	NO	NO	100	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.5	10.7	1.92	1.2	231	YES	NO	NO	YES	YES	NO	TSH-2	NO	YES	SINUS TACHYCARDIA	YES	NO	NO	<5	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.6	5.9	1.96	1.2	342	YES	NO	NO	YES	YES	NO	TSH-2.77	YES	NO	NORMAL SINUS RHYTM	YES	NO	NO	65	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, TENDER ON RIGHT SIDE, NO ORGANOMEGALY	10.5	13.4	2.7	0.48	108	YES	NO	NO	YES	YES	NO	TSH-4	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.1	5.1	2.2	0.65	86	YES	NO	NO	YES	YES	NO	TSH-4.2	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.1	17	2.68	1.24	304	YES	NO	NO	YES	YES	NO	TSH-3	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	YES

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
YES	NO	NO	32.9	104	5'10"	NO	YES	120/85	94	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.8	107	5'10"	YES	NO	120/90	96	YES	NO	NO	NO	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	100/60	97	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.2	105	5'10"	YES	NO	100/60	98	YES	NO	NO	NO	NO	NO
NO	NO	YES	40.2	120	5'8"	YES	NO	130/80	92	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.8	80	5'5"	NO	YES	110/70	93	YES	NO	NO	NO	NO	NO
YES	NO	YES	37.1	95	5'3"	YES	NO	124/60	79	YES	NO	NO	NO	NO	NO
YES	NO	YES	37.1	98	5'4"	YES	NO	140/90	75	YES	NO	NO	NO	NO	NO
NO	NO	NO	34.5	109	5'10"	YES	NO	130/70	84	NO	NO	NO	YES	NO	NO
YES	NO	NO	32.2	85	5'4"	YES	NO	130/70	81	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.5	100	5'8"	NO	YES	112/80	91	YES	NO	NO	NO	NO	NO
YES	NO	NO	31.7	103	5'11"	NO	YES	128/60	102	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.5	100	5'8"	YES	NO	124/60	117	YES	NO	NO	NO	NO	NO
NO	YES	YES	40.2	120	5'8"	YES	NO	130/90	102	YES	NO	NO	NO	NO	NO
NO	YES	NO	33.5	100	5'8"	YES	NO	120/84	94	NO	NO	NO	NO	NO	YES
NO	YES	NO	31.7	103	5'11"	NO	YES	130/60	97	YES	NO	NO	NO	NO	NO
NO	NO	YES	44.4	110	5'2"	YES	NO	100/60	84	NO	NO	NO	YES	NO	NO
YES	NO	NO	33.5	100	5'8"	YES	NO	130/80	87	YES	NO	NO	NO	NO	NO
NO	YES	NO	33.5	100	5'8"	YES	NO	110/70	89	YES	NO	NO	NO	NO	NO
NO	NO	YES	47.6	108	5'2"	YES	NO	124/60	86	NO	NO	NO	YES	NO	NO
NO	NO	YES	36.9	110	5'8"	YES	NO	140/90	112	NO	NO	NO	YES	NO	NO
NO	YES	YES	34.2	108	5'10"	YES	NO	130/70	101	YES	NO	NO	NO	NO	NO
NO	YES	YES	35.4	112	5'10"	YES	NO	140/90	105	NO	YES	NO	NO	NO	NO
NO	NO	NO	34.2	108	5'10"	YES	NO	150/70	109	NO	YES	NO	NO	NO	NO
NO	NO	NO	31.7	103	5'11"	YES	NO	160/90	117	NO	NO	NO	YES	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS						
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	CNS
				URBAN	RURAL				30-35	35-40	>40																	
174	SR	60YRS	FEMALE	YES	NO	1044109	07-Mar	12-Mar	34.8			YES	NO	NO	6	YES	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
175	CG	19 YRS	MALE	YES	NO	1044135	07-Mar	10-Mar	30.1			no	YES	NO	4	NO	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
176	SR	55 YRS	FEMALE	YES	NO	1044121	07-Mar	14-Mar		39.7		YES	NO	NO	8	YES	YES	NO	NO	NO	YES	YES	NO	NO	YES	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
177	K	58 YRS	FEMALE	YES	YES	1044052	07-Mar	11-Mar			47.6	YES	NO	NO	5	YES	YES	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
178	SCG	73 YRS	MALE	NO	YES	101275	07-Mar	12-Mar		36.9		YES	NO	NO	6	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
179	BK	36 YRS	MALE	YES	NO	1044514	08-Mar	11-Mar	34.2			no	YES	NO	4	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
180	RS	58 YRS	MALE	YES	NO	1044170	08-Mar	28-Mar		38		YES	NO	NO	20	YES	NO	NO	YES	YES	NO	YES	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
181	PS	52 YRS	MALE	NO	YES	1045329	08-Mar	08-Mar	33.2			no	YES	NO	1	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
182	BS	67 YRS	MALE	YES	NO	1045390	08-Mar	12-Mar		36.4		YES	NO	NO	5	YES	YES	YES	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
183	HC	60YRS	MALE	YES	NO	1046159	09-Mar	13-Mar	34.2			no	YES	NO	5	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
184	N	22 YRS	FEMALE	NO	YES	1047720	10-Mar	15-Mar	31.7			no	YES	NO	6	NO	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
185	MS	50 YRS	MALE	NO	YES	1050471	13-Mar	13-Mar		37.3		no	YES	NO	1	NO	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
186	DM	60 YRS	FEMALE	YES	NO	1049626	13-Mar	16-Mar		35.4		no	YES	NO	4	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
187	UB	66 YRS	FEMALE	NO	YES	60554	15-Mar	19-Mar			47.6	YES	NO	NO	19	YES	NO	YES	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
188	HK	66 YRS	FEMALE	NO	YES	785733	16-Mar	19-Mar		37.3		YES	NO	NO	4	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
189	AS	70 YRS	MALE	NO	YES	1054136	16-Mar	27-Mar		36.9		no	YES	NO	11	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
190	BB	57 YRS	MALE	YES	NO	1054166	17-Mar	17-Mar	30.7			no	YES	NO	1	YES	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
191	SK	78 YRS	MALE	NO	YES	111923	17-Mar	22-Mar	31			no	YES	NO	6	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
192	HK	65 YRS	FEMALE	NO	YES	967559	18-Mar	25-Mar	34.2			YES	NO	NO	8	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
193	G	27 YRS	MALE	NO	YES	1055611	18-Mar	23-Mar	31.7			no	YES	NO	6	NO	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
194	PS	63 YRS	FEMALE	YES	NO	1055437	18-Mar	21-Mar	33.5			no	YES	NO	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
195	GS	46 YR	MALE	NO	YES	1055439	18-Mar	18-Mar	30.7			no	YES	NO	1	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
196	AK	39 YR	MALE	NO	YES	1059201	18-Mar	20-Mar	32.3			no	YES	NO	3	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
197	BS	71 YRS	MALE	YES	NO	972314	18-Mar	19-Mar	30.8			no	YES	NO	2	YES	YES	NO	NO	NO	YES	YES	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
198	S	76 YR	FEMALE	YES	YES	682904	19-Mar	25-Mar	34.8			no	YES	NO	7	YES	YES	NO	YES	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.8	20	1.96	1.1	243	YES	NO	NO	YES	YES	NO	TSH-2	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	100	NO	NO	NO	YES	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	20	2.8	1.08	108	YES	NO	NO	YES	YES	NO	TSH1.9	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.7	16	1.93	0.88	112	YES	NO	NO	YES	YES	NO	TSH-2.3	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	7.9	2.5	2.1	0.6	308	NO	YES	YES	NO	NO	YES	TSH-9	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	6.5	29.7	2.28	0.6	308	YES	NO	NO	YES	YES	NO	TSH--2.8	YES	NO	NORMAL SINUS RHYTM	YES	NO	NO	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.6	4.9	2.6	0.69	112	YES	NO	NO	YES	YES	NO	TSH--2.8	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.8	14	1.9	0.97	108	NO	YES	YES	NO	NO	YES	TSH--2.9	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.8	11.6	3.85	0.89	288	YES	NO	NO	YES	YES	NO	TSH-0.58	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	9.4	7	3.23	1.28	302	YES	NO	NO	YES	YES	NO	TSH--1.30	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	108	NO	NO	NO	YES	YES	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	13.3	4.2	1.6	282	YES	NO	NO	YES	YES	NO	TSH--2.7	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.9	5.6	2.6	0.6	84	YES	NO	NO	YES	YES	NO	TSH--2.6	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	YES	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	FIRM, TENDER DIFFUSELY, NO ORAGNOMEGALY	8.4	13	2.2	0.7	81	YES	NO	NO	YES	YES	NO	TSH-0.58	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	YES	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	14	2.9	0.4	345	YES	NO	NO	YES	YES	NO	TSH--1.30	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.7	5.8	2.8	1	345		YES	YES	NO	NO	YES	TSH-10	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.2	5.3	2.33	1.02	257	YES	NO	NO	YES	YES	NO	TSH-5.70	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L SCATTERED CREPTS	SOFT, NON TENDER, NO ORGANOMEGALY	8.7	6.4	2.2	1.09	348	YES	NO	NO	YES	YES	NO	TSH-5.28	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L SCATTERED CREPTS	SOFT, NON TENDER, NO ORGANOMEGALY	11.1	4.6	2.9	1.16	275	YES	NO	NO	YES	YES	NO	TSH-1.44	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L SCATTERED CREPTS	SOFT, NON TENDER, NO ORGANOMEGALY	13.6	8.8	2.5	1.2	258	YES	NO	NO	YES	YES	NO	TSH-2.4	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.4	6.8	2.04	1.14	245	YES	NO	NO	YES	YES	NO	TSH-2.97	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.4	3.2	4.62	0.6	102	YES	NO	NO	YES	YES	NO	TSH-3.9	NO	YES	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	5.4	3.6	1.09	330	YES	NO	NO	YES	YES	NO	TSH-13.9	YES	NO	NORMAL SINUS RHYTM	YES	NO	NO	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.5	7.7	2.3	0.74	235	YES	NO	NO	YES	YES	NO	TSH-1.18	YES	NO	SINUS TACHYCARDIA	YES	NO	NO	100	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.9	4.3	3.8	0.76	258	YES	NO	NO	YES	YES	NO	TSH-0.45	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	102	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13.5	12.6	2.5	0.9	305	YES	NO	NO	YES	YES	NO	TSH-1.16	NO	YES	SINUS TACHYCARDIA	YES	NO	NO	100	NO	YES	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.5	25	2.11	0.96	242	YES	NO	NO	YES	YES	NO	TSH-2	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
NO	NO	YES	34.8	110	5'10"	YES	NO	140/90	98	NO	NO	NO	YES	NO	NO
NO	NO	NO	30.1	95	5'10"	NO	YES	144/78	99	NO	NO	NO	YES	NO	NO
NO	NO	YES	39.7	115	5'7"	YES	NO	150/90	95	NO	NO	NO	YES	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	164/80	96	YES	NO	NO	NO	NO	NO
YES	NO	YES	36.9	110	5'8"	YES	NO	140/90	93	YES	NO	NO	NO	NO	NO
NO	YES	NO	34.2	108	5'10"	YES	NO	130/70	79	YES	NO	NO	NO	NO	NO
NO	YES	YES	38	110	5'7"	YES	NO	120/60	78	YES	NO	NO	NO	NO	NO
NO	NO	NO	33.2	108	5'11"	YES	NO	110/70	73	NO	YES	NO	NO	NO	NO
NO	NO	YES	36.4	115	5'10"	YES	NO	140/90	76	YES	NO	NO	NO	NO	NO
NO	YES	NO	34.2	108	5'10"	YES	NO	130/60	102	NO	NO	NO	NO	NO	YES
NO	NO	NO	31.7	103	5'11"	NO	YES	122/80	81	NO	YES	NO	NO	NO	NO
NO	NO	NO	37.3	108	5'7"	YES	NO	124/60	83	NO	YES	NO	NO	NO	NO
YES	NO	NO	35.4	115	5'11"	YES	NO	110/70	86	YES	NO	NO	NO	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	120/70	89	YES	NO	NO	NO	NO	NO
YES	NO	YES	37.3	118	5'10"	YES	NO	112/60	84	YES	NO	NO	NO	NO	NO
YES	NO	NO	36.9	110	5'8"	YES	NO	140/90	89	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.7	100	5'11"	YES	NO	130/70	78	YES	NO	NO	NO	NO	NO
NO	YES	NO	31	98	5'10"	NO	YES	140/90	87	YES	NO	NO	NO	NO	NO
YES	NO	YES	34.2	108	5'10"	YES	NO	150/70	97	YES	NO	NO	NO	NO	NO
YES	NO	NO	31.7	103	5'11"	NO	YES	160/90	97	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.5	100	5'8"	YES	NO	140/90	94	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.7	100	5'11"	YES	NO	144/78	96	YES	NO	NO	NO	NO	NO
NO	YES	NO	32.3	105	5'11"	YES	NO	150/90	95	NO	NO	NO	NO	NO	YES
NO	NO	NO	30.8	80	5'5"	YES	NO	164/80	98	NO	NO	NO	YES	NO	NO
NO	YES	NO	34.8	110	5'10"	YES	NO	140/90	87	YES	NO	NO	NO	NO	NO

Sr. No	NAME	AGE	GENDER	AREA		MRD	DOA	DOD	BMI			OUTCOME			HOSPITAL STAY	COMORBIDITY				DIETARY HABITS		PREDOMINANT SYMPTOMS							
												MORTALITY	DISCHARGE	DISCHARGE AGAINST MEDICAL ADVISE	(DAYS)	TYPE-II DM	HTN	HYPOTHYROIDISM	OTHERS	VEGETARIAN	NON-VEGETARIAN	FEVER	COUGH	BREATHLESSNESS	PAIN ABDOMEN	BURNING MICTURITION	OTHER	CNS
				URBAN	RURAL				30-35	35-40	>40																	
199	CB	65 YRS	FEMALE	YES	NO	1057427	19-Mar	26-Mar		36.2		YES	NO	NO	8	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
200	RK	45 YRS	MALE	NO	YES	1056536	19-Mar	22-Mar	34.4			no	NO	YES	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
201	SC	70 YRS	MALE	YES	NO	754353	19-Mar	23-Mar		35.4		YES	NO	NO	5	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
202	M	58 YRS	FEMALE	YES	NO	1058021	20-Mar	24-Mar		39.6		YES	NO	NO	5	YES	YES	NO	NO	NO	YES	NO	NO	YES	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
203	H	22 YRS	FEMALE	NO	YES	21574	22-Mar	27-Mar	33.2			no	NO	YES	6	NO	NO	NO	NO	YES	NO	NO	NO	NO	YES	YES	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
204	AK	66 YRS	FEMALE	YES	NO	1061646	22-Mar	25-Mar	32.3			no	NO	YES	4	YES	NO	NO	NO	YES	NO	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
205	BR	57 YRS	MALE	YES	NO	1061609	23-Mar	29-Mar	30.7			no	YES	NO	8	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
206	K	58 YRS	MALE	NO	YES	1033545	23-Mar	30-Mar		36.9		no	YES	NO	9	YES	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
207	AS	66 YRS	MALE	NO	YES	1064588	25-Mar	28-Mar	32.9			no	YES	NO	4	YES	YES	NO	NO	NO	YES	NO	NO	NO	NO	NO	YES	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
208	RS	58 YRS	FEMALE	NO	YES	1067080	28-Mar	31-Mar	33.2			no	NO	YES	4	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
209	G	56 YR	MALE	NO	YES	1067205	28-Mar	15-Apr			40.2	YES	NO	NO	18	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
210	MK	75 YRS	FEMALE	YES	NO	1068824	30-Mar	14-Apr		35.3		YES	NO	NO	15	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
211	AS	55 YRS	MALE	NO	YES	1072902	30-Mar	14-Apr		36.9		no	YES	NO	17	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
212	DR	60 YR	MALE	NO	YES	1070508	31-Mar	17-Apr		35		no	NO	YES	19	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
213	SS	45 YRS	MALE	YES	NO	1069996	31-Mar	11-Apr		36.9		YES	NO	NO	13	NO	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
214	K	62 YRS	FEMALE	NO	YES	1071131	31-Mar	02-Apr	30.8			no	YES	NO	3	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
215	KK	52 YRS	FEMALE	NO	YES	1068690	31-Mar	11-Apr			47.6	YES	NO	NO	12	YES	YES	YES	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON
216	MK	82 YRS	FEMALE	NO	YES	171271	27-Mar	31-Mar	32.9			no	YES	NO	5	YES	YES	NO	NO	NO	YES	YES	NO	NO	NO	NO	NO	E4V5M6; CONSCIOUS, ORIENTED TO TIME PLACE AND PERSON

SYSTEMIC EXAMINATION			LAB INVESTIGATIONS																						DIAGNOSIS		
CVS	RESPIRATORY	ABDOMINAL	HEMOGLOBIN	TLC	ALBUMIN	CREATININE	RBS	LIPID PROFILE						THYROID PROFILE	cx		ECG	2D ECHO			BNP	HbA1c				TYPE-II RESPIRATORY FAILURE	ACUTE PANCREATITIS	UTI
								LDL		HDL		TRIGLYCERIDES			FATTY LIVER			DIASTOLIC DYFUNCTION	SYSTOLIC DYSFUNCTION	NORMAL ECHO								
								<160	>160	>40	<40	<200	>200		PRESENT	ABSENT						5-6g%	6-8g%	8-10g%	>10g%			
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.1	15.9	2.3	0.65	308	YES	NO	NO	YES	YES	NO	TSH-3.4	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.1	4.4	2.2	0.54	278	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	4.9	2.2	0.92	320	YES	NO	NO	YES	YES	NO	TSH6	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	8.1	16	2.9	1.21	248	YES	NO	NO	YES	YES	NO	TSH1.8	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.1	11	2.2	0.76	102	YES	NO	NO	YES	YES	NO	TSH-3	NO	YES	SINUS TACHYCARDIA	NO	NO	YES	<5	YES	NO	NO	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.6	9.2	2.3	0.2	258	YES	NO	NO	YES	YES	NO	TSH3.4	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	14.2	9.7	2.8	0.8	495	YES	NO	NO	YES	YES	NO	TSH-6	YES	NO	NORMAL SINUS RHYTM	YES	NO	NO	<5	NO	NO	YES	NO	NO	NO	YES
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	10.9	14	2.2	0.77	335	YES	NO	NO	YES	YES	NO	TSH-2	NO	YES	SINUS TACHYCARDIA	YES	NO	NO	108	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	16	2.1	0.7	220	YES	NO	NO	YES	YES	NO	TSH-3.4	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	5	3.1	0.69	238	NO	YES	YES	NO	NO	YES	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12.7	12	2.8	0.6	245	YES	NO	NO	YES	YES	NO	TSH6	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L SCATTERED CREPTS	SOFT, NON TENDER, NO ORGANOMEGALY	11.8	6.7	2.2	0.82	254	YES	NO	NO	YES	YES	NO	TSH1.8	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L SCATTERED CREPTS	SOFT, NON TENDER, NO ORGANOMEGALY	14	13	2.22	0.72	300	YES	NO	NO	YES	YES	NO	TSH-3	YES	NO	NORMAL SINUS RHYTM	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	12	2.22	1.5	308	YES	NO	NO	YES	YES	NO	TSH3.4	YES	NO	NORMAL SINUS RHYTHM	YES	NO	NO	108	NO	NO	YES	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	8.3	2.17	0.6	112	YES	NO	NO	YES	YES	NO	TSH-6	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	100	NO	YES	NO	NO	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	11	12	2.6	0.54	335	YES	NO	NO	YES	YES	NO	TSH-2	YES	NO	NORMAL SINUS RHYTHM	YES	NO	NO	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	13	8	2.4	0.52	305	NO	YES	YES	NO	NO	YES	TSH-10	YES	NO	SINUS TACHYCARDIA	NO	NO	YES	<5	NO	NO	NO	YES	NO	NO	NO
NORMAL S1S2; NO ADDED SOUND	B/L VESICULAR BREATH SOUNDS	SOFT, NON TENDER, NO ORGANOMEGALY	12	14	1.8	0.58	205	YES	NO	NO	YES	YES	NO	TSH-5	YES	NO	NORMAL SINUS RHYTHM	NO	NO	YES	<5	NO	YES	NO	NO	NO	NO	NO

		OSA	BMI (KG/M2)	WEIGHT	HEIGHT	WAIST HI P RATIO		VITALS		SYSTEM PREDOMINANTLY INVOLED					
COVID PNEUMONITIS	OTHERS					>1.00 MALE/ >0.85 FEMALE	<1.00 MALE/< 0.85 FEMALE	BP	HR	RESPIRATORY	GASTROENTEROLGY	NEUROLOGICAL	GENITOURINARY	CARDIAC	OTHERS
YES	NO	YES	36.2	108	5'8"	YES	NO	130/70	88	YES	NO	NO	NO	NO	NO
NO	YES	NO	34.4	112	5'11"	YES	NO	140/90	96	NO	NO	NO	NO	NO	YES
NO	NO	NO	35.4	115	5'11"	YES	NO	150/70	54	NO	NO	NO	NO	NO	YES
NO	YES	YES	39.6	118	5'8"	YES	NO	130/60	99	NO	NO	NO	NO	YES	NO
NO	NO	NO	33.2	108	5'11"	NO	YES	130/60	102	NO	NO	NO	YES	NO	NO
YES	NO	NO	32.3	108	6'	YES	NO	122/80	111	YES	NO	NO	NO	NO	NO
NO	NO	NO	30.7	100	5'11"	NO	YES	124/60	98	NO	NO	NO	YES	NO	NO
NO	YES	NO	36.9	110	5'8"	YES	NO	110/70	92	NO	YES	NO	NO	NO	NO
YES	NO	NO	32.9	110	6'	YES	NO	140/90	93	YES	NO	NO	NO	NO	NO
YES	NO	NO	33.2	108	5'11"	YES	NO	130/70	65	YES	NO	NO	NO	NO	NO
YES	NO	YES	40.2	120	5'8"	YES	NO	140/90	76	YES	NO	NO	NO	NO	NO
YES	NO	YES	35.3	118	6'	YES	NO	150/70	77	YES	NO	NO	NO	NO	NO
YES	NO	NO	36.9	110	5'8"	YES	NO	160/90	72	YES	NO	NO	NO	NO	NO
YES	NO	NO	34.8	110	5'10"	YES	NO	140/90	84	YES	NO	NO	NO	NO	NO
YES	NO	YES	36.9	110	5'8"	YES	NO	144/78	78	YES	NO	NO	NO	NO	NO
YES	NO	NO	30.8	80	5'5"	NO	YES	150/90	85	YES	NO	NO	NO	NO	NO
YES	NO	YES	47.6	108	5'2"	YES	NO	164/80	86	YES	NO	NO	NO	NO	NO
YES	NO	NO	32.9	110	6'	YES	NO	140/84	84	YES	NO	NO	NO	NO	NO

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No. BFUHS/2K21p-TH/ 5476

Date 28/4/2021

The Principal,
DMC,Ludhiana.

Subject: **Approval of Plan of Thesis.**

This is to inform you that the Faculty of Medical Sciences in its meeting held on 22.01.2021 has approved the plan of thesis of **Dr. Kanchan**, a student of your college for **MD General Medicine** along with the names of Supervisor/Co-Supervisor as under:-

Topic Plan of Thesis
Clinical profile of obese patients

Supervisor
Dr. Vipin Kumar
Asst. Prof.,
Dept. of Medicine,
DMCH, Ludhiana.

Co-Supervisor
Dr. Sandeep Puri
Prof.,
Dept. of Medicine,
DMCH, Ludhiana.
Dr. H.S. Dhooria
Assoc. Prof.,
Dept. of Medicine,
DMCH, Ludhiana.

The student has to submit the three copies of thesis (along with PDF format) , to the Controller of Examinations, BFUHS, Faridkot, at least six months before the commencement of theory examination, if he/she is otherwise eligible to take the examination. He /She must directed to attach a photocopy of this letter with the forwarding letter while submitting thesis to the University along with the letter of approval of University for change of supervisor/Co-Supervisor, change of topic,(if any).

Dr. S P Singh MS(Oph)
Controller of Examinations

Note :

1. ***If any discrepancy found regarding topic of thesis or Supervisor/Co-Supervisor, inform undersigned within one month after issue of this letter.***
2. *The student may submit the thesis as per the schedule already conveyed i.e for May/June examination 30th Nov of the preceding the year of examination and for Nov/Dec examinations 31st May of the year of examination.*

CLINICAL PROFILE OF OBESE PATIENTS

THESIS PROPOSAL

FOR APPROVAL OF SUBJECT OF THESIS TO BE SUBMITTED

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF MEDICINE

In

MEDICINE

OF THE

BABA FARID UNIVERSITY OF HEALTH SCIENCES
FARIDKOT

NOVEMBER, 2019

DR. KANCHAN

DEPARTMENT OF MEDICINE
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA

ABSTRACT OF PLAN OF THESIS

Title	CLINICAL PROFILE OF OBESE PATIENTS
For the degree of	MD Medicine
Name of the candidate	Dr Kanchan
Supervisor	Dr Vipin Kumar, Assistant Professor, Department of Medicine, DMCH
Co-supervisor	Dr Sandeep Puri, Professor, Department of Medicine, DMCH Dr H.S. Dhooria, Associate Professor, Department of Medicine, DMCH
Institution	Dayanand Medical College & Hospital, Ludhiana
University	Baba Farid University of Health Sciences, Faridkot

Introduction: WHO defines obesity as state of excess adipose tissue mass. The most widely used method to gauge obesity is body mass index (BMI). BMI of >30kg/m^2 is defined as obese for both male & female. Obesity is associated with an increased risk of multiple health problems. With increased prevalence, obesity plays an important role in modifying treatment outcomes associated with co morbid diseases.With its array of co morbidities, obesity necessitates careful clinical assessment to identify underlying factors and to allow coherent management.

Aim of Study: Obesity is a major health problem, yet neglected and under studied. 1) To evaluate indication for admission in obese patients who are admitted in medical wards. 2) To assess outcome of admitted obese patients. 3) To collect data for clinical profile of obese patients.

Materials & Methods: It is an observational study which will be conducted at DMCH, Ludhiana. In a study period of 1 year, obese patients with BMI >30kg/m^2, admitted to medicine wards will be analysed for their presenting complaints and body system involved. Association of obesity with various co-morbidities will be determined.

Clinical Significance: Co morbidities associated with obesity will be observed to determine the prevalence in obese inpatient population & their cause of admission.

Keywords: Obesity, co morbidities, and outcome

(Signature) Candidate	(Signature) Co-supervisor	(Signature) Co-supervisor	(Signature) Supervisor	(Signature) Principal

CERTIFICATE OF FACILITIES AVAILABLE

This is to certify that the facilities for work on the subject of thesis titled **"CLINICAL PROFILE OF OBESE PATIENTS"** exist in the Department of MEDICINE, DMC&H, Ludhiana and will be provided to be candidate of will be provided to the candidate. We will see that the data being included in the thesis are genuine and is collected by the candidate himself/herself under our supervision and guidance.

Supervisor

Dr Vipin Kumar
Assistant Professor
Department of Medicine
DMCH, Ludhiana

Co-Supervisor

Dr Sandeep Puri
Professor & Principal
Department of Medicine
DMCH, Ludhiana

Dr H.S. Dhooria
Associate Professor
Department of Medicine
DMCH, Ludhiana

Head of the Department

Dr. Dinesh Gupta
Professor & Head
Department of Medicine
DMCH

Place : _____

Date : _____

APPROVAL PROFORMA
BY
RESEARCH & ETHICAL COMMITTEE
DAYANAND MEDICAL COLLEGE & HOSPITAL, LUDHIANA

Name of candidate	DR KANCHAN
Department	MD MEDICINE
Topic of Thesis	CLINICAL PROFILE OF OBESE PATIENTS
Likely date of appearing in PG examination	JAN 2022
Date of enrollment	
Name of Head of Department	DR DINESH GUPTA
1) Supervisor **2) Co-Supervisor**	DR VIPIN KUMAR DR SANDEEP PURI DR H.S. DHOORIA
Signature of Members of Research Committee with Stamp	**Signature of Members of Ethics Committee with Stamp**
Dr. Jaspal Singh (Professor & Head, Surgery)	Mr. A K Jindal (Member, Ethics Committee)
Dr. Dinesh Gupta (Professor & Head, Medicine)	Dr. Anu Sharma (Professor, Anatomy)
Dr. Sandeep Kaushal (Assistant Dean Academics)	Dr. Deepinder K Chhina (Professor & Head, Microbiology)
Dr. Rajoo Singh Chhina (Dean Academics)	Dr. Neena Sood (Professor & Head, Pathology)
Dr. Gurpreet S Wander (Vice Principal)	Dr. Gurpreet S Wander (Vice Principal)
	Dr. Gagandeep Singh (Secretary, Ethics Committee Professor & Head, Neurology)

Approved: Yes / ~~No~~

Dr. Sandeep Puri
Chairperson
Research Committee

Chairperson
Research Committee

Approved: Yes / ~~No~~

Prof. Arvind Malhotra
Chairperson
Ethics Committee

Chairperson
Ethics Committee

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

At the other end of the malnutrition scale, obesity is one of today's most blatantly visible – yet most neglected – public health problems. Paradoxically coexisting with under nutrition, an escalating global epidemic of overweight and obesity – "globesity" – is taking over many parts of the world. If immediate action is not taken, millions will suffer from an array of serious health disorders. The prevalence of obesity has reached epidemic proportions in many countries around the World and as per WHO estimates, more than one billion adults are overweight and over 300 million are obese. Obesity is a complex condition, one with serious social and psychological dimensions, that affects virtually all age and socioeconomic groups and threatens to overwhelm both developed and developing countries. It is associated with an increased risk of multiple health problems. WHO describes obesity as most visible but most neglected public health problem. With increased prevalence, obesity plays an important role in modifying treatment outcomes associated with co morbid diseases. Over and above any economic impact of obesity on the use of hospital resources, these findings should inform clinicians and their patients about the preventable and possibly under-recognized associations of obesity in hospital inpatients. Excess bodyweight is the sixth most important risk factor contributing to the overall burden of disease worldwide. Obesity is considered as a multifactorial and heterogeneous disease due to complex interaction of genetic and environmental factors. Studies involving genetic and molecular analysis of obesity have identified major genes involved in the regulation of energy expenditure and energy intake. Interaction of many genetic variants with one another and with environment predisposes to weight gain and ultimately leads to obesity in most of the cases. Quite often, obesity results from chronic energy surplus with dietary caloric intake exceeding energy expenditure. Within populations, the interaction

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT

PROFORMA FOR REGISTRATION OF SUBJECT FOR DISSERTATION

1	NAME OF THE CANDIDATE AND ADDRESS	DR KANCHAN PG RESIDENT DMCH, LUDHIANA
2	NAME OF THE INSTITUTE	DAYANAND MEDICAL COLLEGE AND HOSPITAL, LUDHIANA
3	COURSE OF STUDY AND SUBJECT	MD MEDICINE
4	DATE OF ADMISSION OF COURSE	1ST MAY 2019
5	TITLE OF THE TOPIC	CLINICAL PROFILE OF OBESE PATIENTS

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

At the other end of the malnutrition scale, obesity is one of today's most blatantly visible – yet most neglected – public health problems. Paradoxically coexisting with under nutrition, an escalating global epidemic of overweight and obesity – "globesity" – is taking over many parts of the world. If immediate action is not taken, millions will suffer from an array of serious health disorders. The prevalence of obesity has reached epidemic proportions in many countries around the World and as per WHO estimates, more than one billion adults are overweight and over 300 million are obese. Obesity is a complex condition, one with serious social and psychological dimensions, that affects virtually all age and socioeconomic groups and threatens to overwhelm both developed and developing countries. It is associated with an increased risk of multiple health problems. WHO describes obesity as most visible but most neglected public health problem. With increased prevalence, obesity plays an important role in modifying treatment outcomes associated with co morbid diseases. Over and above any economic impact of obesity on the use of hospital resources, these findings should inform clinicians and their patients about the preventable and possibly under-recognized associations of obesity in hospital inpatients. Excess bodyweight is the sixth most important risk factor contributing to the overall burden of disease worldwide. Obesity is considered as a multifactorial and heterogeneous disease due to complex interaction of genetic and environmental factors. Studies involving genetic and molecular analysis of obesity have identified major genes involved in the regulation of energy expenditure and energy intake. Interaction of many genetic variants with one another and with environment predisposes to weight gain and ultimately leads to obesity in most of the cases. Quite often, obesity results from chronic energy surplus with dietary caloric intake exceeding energy expenditure. Within populations, the interaction

between environmental and individual factors including genetic makeup explains variability in body size between individuals. 1.1 billion Adults and 10% of children are now classified as overweight or obese. Generally, although men may have higher rates of overweight, women have higher rates of obesity. For both, obesity poses a major risk for serious diet-related non-communicable diseases, including diabetes mellitus, cardiovascular disease, hypertension and stroke, and certain forms of cancer. Its health consequences range from increased risk of premature death to serious chronic conditions that reduce the overall quality of life. Average life expectancy is already diminished; the main adverse consequences are cardiovascular disease, type 2 diabetes, and several cancers. The complex pathological processes reflect environmental and genetic interactions, and individuals from disadvantaged communities seem to have greater risks than more affluent individuals partly because of fetal and postnatal imprinting. Obesity, with its array of co morbidities, necessitates careful clinical assessment to identify underlying factors and to allow coherent management. The epidemic reflects progressive secular and age-related decreases in physical activity, together with substantial dietary changes with passive over-consumption of energy despite the neurobiological processes controlling food intake. As there is paucity of data regarding obesity in India, the need to study obesity and its effects on co morbidities becomes important. During hospital stay, patient would be more receptive to the counseling about weight reduction, dietary recommendations and awareness about effects of obesity on their health. There is a need to collect data regarding correlation of obesity with different diseases. It is important to study obesity paradox as seen with various conditions, usually found in hospitalized patients. Obesity paradox is under studied subject; it can affect treatment outcome of the obese patients. Obesity was once considered a problem of high income countries, but overweight & obesity are now dramatically on rise in low and middle income countries too. Contrary to conventional wisdom, the obesity epidemic is not restricted to industrialized societies; in developing countries, it is estimated that

over 115 million people suffer from obesity-related problems. Our day by day increased reliance on technology has reduced work-related physical activity and unlimited supply of convenient, relatively inexpensive, highly palatable energy dense foods is leading us to overweight and obesity in our current environment. Traditional treatment strategies and public health interventions aimed at reducing the incidence of obesity are proving inadequate in controlling the global epidemic of this condition. All countries are searching for answers about how to reverse the rising tide of adult and childhood obesity. Despite many obesity preventive strategies recommended and adopted at individual and national level, the epidemic of obesity continues to rise in segments of populations in developed and developing countries. The only effective approach may be for governments to implement radical policy change, to regulate food industry and food consumption in a similar way to that of tobacco and alcohol industry by banning attractive food advertisements and taxing certain types of foods. At the same time, we must inspire people to make behavior changes within the current environment that are sufficient to resist the push of environmental factors toward weight gain. Increasing physical activity may be the strategy of choice for public health efforts to prevent obesity. Appropriated interventions and collaborative efforts at individuals, health professionals, industry and government level may help to reduce the obesity epidemic and its deadly consequences under present circumstances. Effective long-term weight loss depends on permanent changes in dietary quality, energy intake, and activity. Neither the medical management nor the societal preventive challenges are currently being met.

6.2 REVIEW OF LITERATURE

WHO defines obesity as state of excess adipose tissue mass. The most widely used method to gauge obesity is body mass index (BMI). BMI of >30kg/m^2 is defined as obese for both male & female.

Various studies inferred obesity to be related to multiple co-morbidities. Like Haslam Dw [1] concluded that excess bodyweight is the sixth most important risk factor contributing to the overall burden of disease worldwide. 1.1 billion adults and 10% of children are now classified as overweight or obese. Average life expectancy is already diminished; the main adverse consequences are cardiovascular disease, type 2 diabetes, and several cancers. The complex pathological processes reflect environmental and genetic interactions, and individuals from disadvantaged communities seem to have greater risks than more affluent individuals partly because of fetal and postnatal imprinting. Obesity, with its array of co morbidities, necessitates careful clinical assessment to identify underlying factors and to allow coherent management. The epidemic reflects progressive secular and age-related decreases in physical activity, together with substantial dietary changes with passive over-consumption of energy despite the neurobiological processes controlling food intake. Effective long-term weight loss depends on permanent changes in dietary quality, energy intake, and activity. Neither the medical management nor the societal preventive challenges are currently being met.

Studies have been done to define overweight and obesity, like in a study by Engin et al [2], it was concluded that Increase in prevalence of obesity has become a worldwide major health problem in adults, as well as among children and adolescents. Furthermore, total adiposity and truncal subcutaneous fat accumulation during adolescence are positively and independently associated with atherosclerosis at adult ages. Centrally accumulation of body fat is associated with insulin resistance, whereas distribution of body fat in a peripheral pattern is metabolically less important. Obesity is associated with a large decrease in life expectancy. The effect of extreme obesity on mortality is greater among younger than older adults. In this respect, obesity is

also associated with increased risk of several cancer types. However, up to 30% of obese patients are metabolically healthy with insulin sensitivity similar to healthy normal weight individuals, lower visceral fat content, and lower intima media thickness of the carotid artery than the majority of metabolically "unhealthy" obese patients. Abdominal obesity is the most frequently observed component of metabolic syndrome. The metabolic syndrome; clustering of abdominal obesity, dyslipidemia, hyperglycemia and hypertension, is a major public health challenge. The average prevalence of metabolic syndrome is 31%, and is associated with a two-fold increase in the risk of coronary heart disease, cerebrovascular disease, and a 1.5-fold increase in the risk of all-cause mortality.

Obesity is related to multiple co morbidities as noticed in the study by Guh DP et al [3] which concluded that a comprehensive estimate of the incidence of co-morbidities attributable to overweight and obesity using standardized and consistent definitions and methodologies, i.e. diabetes, hypertension, coronary artery disease, congestive heart failure, stroke and gallbladder disease.

There are various kinds of complications related to obesity as seen in study by Q J Met[4] who concluded thatobesity is linked with a large range of medical complications. There is evidence that obesity is not only related to conditions such as diabetes, hypertension, heart disease, obstructive sleep apnea, asthma, non-alcoholic fatty liver disease, osteoarthritis and polycystic ovary syndrome, but also that weight reduction has beneficial effects and therefore is an integral part of treating these morbidities. Although there is a significant association between certain types of cancer and obesity, the inherent limitation of epidemiological studies in establishing causality, together with the lack of intervention studies, underline the need for further studies before the role of obesity in cancer is established.

Overweight and obese have higher number of admissions than normal/underweight as seen by Hart CL et al [5] & by Markoff B et al[6] which concluded that underweight and normal weight men had lower-

than-expected admission rates, and overweight and obese men had higher-than-expected admission rates.

The reason for obese patients getting more icu admissions was noticed by study done by El-Solh A et al.[7] which concluded that obstructive airway disease, pneumonia, and sepsis were the main reasons for admission to the ICU in the morbidly obese group. Sixty-one percent of the morbidly obese patients and 46% of the nonobese group required mechanical ventilation ($p = 0.02$).

Obese patients and ICU as studied by Goulenok Cet al [8] concluded that all patients hospitalized in the ICU over a 1-year period were included except those dying or being discharged from the hospital within 24 h of admission. Overweight patients were defined as those having a BMI > 75th percentile of this selected ICU population. Other data collected were demographic and ICU-related data. The Mann-Whitney test was used to compare numeric data between groups (*ie*, obese and nonobese populations). Variables that were significantly associated with ICU mortality by univariate analysis were entered into a multiple logistic regression model, allowing the determination of independent predictors.

About length of stay of obese patients, Hauck K et al[9] concluded that there are significant differences in average length of stay for almost all specialties. For some, differences are less than 1 day, but for others, severely obese patients stay up to 4 days longer. For a number of specialties, obese patients have significantly shorter length of stay. Overall, medically managed obese patients stay longer, whereas surgically treated patients stay shorter than other patients. Differences tend to increase with length of stay. In another study, EpsteinEpstein AM et al[10] concluded that the relation of body weight to lengths of stay and total charges for all patients hospitalized for total knee replacement and total hip replacement during a 12-month period. Patients with moderate obesity (actual body weight 141-170 per cent of ideal) had lengths of stay and total charges similar to normal weight patients (body weight 100-110 per cent ideal).

Various studies were done regarding BMI like in a study by Zizza C et al[11] it was concluded that individuals with body mass indexes (BMIs) of 35 kg/m^2 or above, those with BMIs of 30 to 34 kg/m^2, and those with BMIs of 25 to 29 kg/m^2 had crude length-of-stay rates greater than those of normal-weight individuals. Association between BMI and length of stay varied over time.

In a study by Liu B et al[12],it was concluded that during follow-up, 24 953 women were admitted with gallbladder disease, 87% who had a cholecystectomy. After adjusting for age, socioeconomic status and other factors, women with higher BMI at recruitment to the study were more likely to be admitted and spend more days in hospital.

Study by Kyle UG, Pirlich M, Lochs H, et al. [13] concluded that reduced lean tissue as well as high fat mass may be independent nutritional risk factors resulting in increased length of hospital stay (LOS).

There is term called "obesity paradox", which has been study by Uretsky S et al[14] who concluded that an obesity paradox, a "paradoxical" decrease in morbidity and mortality with increasing body mass index (BMI), has been shown in patients with heart failure and those undergoing percutaneous coronary intervention. However, whether this phenomenon exists in patients with hypertension and coronary artery disease is not known.In a population with hypertension and coronary artery disease, overweight and obese patients had a decreased risk of primary outcome compared with patients of normal weight, which was driven primarily by a decreased risk of all-cause mortality. Our results further suggest a protective effect of obesity in patients with known cardiovascular disease in concordance with data in patients with heart failure and those undergoing percutaneous coronary intervention.

By surgical point of view, studies have been done for obesity, like Mullen Jt et al [15] concluded that obesity has long been considered a risk factor for poor outcomes from a variety of surgical procedures, yet recent studies of critically and chronically ill patients suggest that overweight and obese patients may paradoxically have better outcomes than "normal" weight patients. Overweight and moderately

obese patients undergoing non-bariatric general surgery have paradoxically "lower" crude and adjusted risks of mortality compared with patients at a "normal" weight. This finding is in contrast to observations from the general population, confirming the existence of an "obesity paradox" in this patient population

Studies have been done regarding PCI and obesity, Schenkeveld L et al[16] concluded that BMI is inversely related to long-term mortality in patients treated with percutaneous coronary intervention. Patients with a normal BMI are on suboptimal medical treatment when compared with those with a high BMI. A more optimal medical treatment in the obese group may explain the observed improved outcome in these patients.

There has been research and advancement in treatment for obesity, in a study by Terranova L et al [17] concluded that Bariatric surgery is to date the most effective treatment for morbid obesity and it has been proven to reduce obesity-related co morbidities and total mortality. As any medical treatment, bariatric surgery is costly and doubts about its affordability have been raised. On the other hand, bariatric surgery may reduce the direct and indirect costs of obesity and related co morbidities. The appreciation of the final balance between financial investments and savings is critical from a health economic perspective. In this paper, we try to provide a brief updated review of the most recent studies on the cost-efficacy of bariatric surgery, with particular emphasis on budget analysis. A brief overview of the economic costs of obesity will also be provided. The epidemic of obesity may cause a significant reduction in life expectancy and overwhelming direct and indirect costs for citizens and societies. Cost-efficacy analyses included in this review consistently demonstrated that the additional years of lives gained through bariatric surgery may be obtained at a reasonable and affordable cost. In groups of patients with very high obesity-related health costs, like patients with type 2 diabetes, the use of bariatric surgery required an initial economic investment, but may save money in a relatively short period of time.

Study by Engel AM et al.[18] concluded that despite the co morbidities that are often present with obesity, an obese BMI was not found to be an independent predictor of morbidity or mortality after CABG. On the contrary, the underweight patients are at greater risk for mortality and complications after CABG surgery.

Study by Yung et al [19] concluded that the difference in phenotypes between the two related heterozygotes, and the observation of obesity in other family members without the mutation suggests that obesity results from a varying combination of environmental, behavioral and multiple genetic factors (other than *MC3R*), even within the same family.

Rasmeih et al [20] concluded that Neck circumference (NC) is a novel simple and stable body measurement, a growing body of evidence indicates its validity to diagnose obesity and metabolic syndrome (MetS). Because the cutoff value of NC is gender and ethnic-specific; we conducted the current study to explore the performance of NC to predict general obesity, central obesity, and MetS among adult Saudis of both genders.

Locke et al [21] concluded that Around 40–70% of inter-individual variability in BMI, commonly used to assess obesity, has been attributed to genetic factors.

6.3 AIMS AND OBJECTIVES OF THE STUDY

Obesity is a major health problem, yet neglected and under studied.

1) To evaluate indication for admission in obese patients who are admitted in medical wards.
2) To assess outcome of admitted obese patients.
3) To collect data for clinical profile of obese patients.

7. MATERIALS AND METHODS

It is an observational study which will be conducted at DMCH, Ludhiana. In a study period of 1 year, obese patients with BMI >30kg/m^2, admitted to medicine wards will be analysed for their presenting complaints and body system involved. Association of obesity with various co-morbidities will be determined.

7.1 SOURCE OF DATA

Medicine wards of DMCH Ludhiana

7.2 METHOD OF COLLECTION OF DATA

Inclusion Criteria

- BMI->30Kg/m^2
- Age- >18 years
- Patient's giving consent for the study

Exclusion Criteria

- Pregnant
- Ascites
- Age <18 years
- Patient's not giving consent

In this observational study, data from all adult patients admitted to hospital for all medicine wards and ICU admissions of patients aged over 18 years. Co morbidities associated with obesity will be observed to determine the prevalence in obese inpatient population & the cause of admission for obese patients who are admitted in tertiary care centre with underlying obesity to determine clinical profile & outcome.

DURATION OF STUDY

1 Year

OUTCOME

Obesity related co-morbidities and reason of prolonged length of stay of obese patients can be determined. Economic impact of obesity on hospital resources can be found and preventable yet possibly under recognized associations of obesity can be analyzed.

7.3 DOES THE STUDY REQUIRE ANY INVESTIGATIONS OR INTERVENTIONS TO BE CONDUCTED ON PATIENTS OR OTHER HUMANS OR ANIMALS? IF SO, PLEASE DESCRIBE BRIEFLY.

NO

7.4 HAS ETHICAL CLEARANCE BEEN OBTAINED FROM YOUR INSTITUTION IN CASE OF 7.3?

Attached herewith

LIST OF REFERENCES

1. Haslam DW, James WPT. Obesity. Lancet. 2005;366:1196–209.
2. Engin A. The definition and prevalence of obesity and metabolic syndrome. Adv Exp Med Biol. 2017;960:1-17.
3. Guh DP, Zhang W, Bansback N, Amarsi Z, Birmingham CL, Anis AH. The incidence of co-morbidities related to obesity and overweight: a systematic review and meta-analysis. BMC Public Health. 2009;9:88
4. Malnick SD, Knobler H. The medical complications of obesity. Q J Met. 2006;99:565–79.
5. Hart CL, Hole DJ, Lawlor DA. Obesity and use of acute hospital resources in participants of the Renfrew/Paisley study. J Public Health. 2007;29:53–6.
6. Markoff B, Amsterdam A. Impact of obesity on hospitalized patients. Mt Sinai J Med. 2008;75:454–9.
7. El-Solh A, Sikka P, Bozkanat E. Morbid obesity in the medical ICU. Chest. 2001;120:1989–97.
8. Goulenok C, Monchi M, Chiche JD. Influence of overweight on ICU mortality: a prospective study. Chest. 2004;125:1441–5.
9. Hauck K, Hollingsworth B. The impact of severe obesity on hospital length of stay. Med Care. 2010;48:335–40.
10. Epstein AM, Read JL, Hoefer M. The relation of body weight to length of stay and charges for hospital services for patients undergoing elective surgery: a study of two procedures. Am J Public Health. 1987;77:993–97.
11. Zizza C, Herring AH, Stevens J. Length of hospital stays among obese individuals. Am J Public Health. 2004;94:1587–91.
12. Liu B, Balkwill A, Spencer E. The Million Women Study Collaborators. Relationship between body mass index and length of hospital stay for gall bladder disease. J Public Health. 2008;30:161–6.

13. Kyle UG, Pirlich M, Lochs H. Increased length of stay in underweight and overweight patients at hospital admission: a controlled population study. Clin Nutr. 2005;24:133–42.
14. Uretsky S, Messerli FH, Bangalore S, Champion A, Cooper-Dehoff RM, Zhou Q, et al. Obesity paradox in patients with hypertension and coronary heart disease. Am J Med. 2007;120:863–70.
15. Mullen JT, Moorman DW, Davenport DL. The obesity paradox: body mass index and outcomes in patients undergoing nonbariatric general surgery. Ann Surg. 2009;250:166–72.
16. Schenkeveld L, Magro M, Oemrawsingh RM, Lenzen M, de Jaegere P, van Geuns RJ, et al. The influence of optimal medical treatment on the 'obesity paradox', body mass index and long-term mortality in patients treated with percutaneous coronary intervention: a prospective cohort study. BMJ Open. 2012;2:e000535.
17. Terranova L, Busetto L, Vestri A, Zappa MA. Bariatric surgery: cost effectiveness and budget impact. Obese Surg. 2012;22:646–53.
18. Engel AM, McDonough S, Smith JM. Does an obese body mass index affect hospital outcomes after coronary artery bypass graft surgery? Ann Thoracic Surg. 2009;88:1793–800.
19. Lee YS, Poh LK, Loke KY. A novel melanocortin 3 receptor gene (mc3r), mutation associated with severe obesity. J Clin Endocrinol Metab. 2002;87:1423-6.
20. Alzeidan R, Fayed A, Hersi AS, Elmorshedy H. Performance of neck circumference to predict obesity and metabolic syndrome among adult Saudis: a cross-sectional study. BMC Obes. 2019;6:13.
21. Locke AE, Kahali B, Berndt SI, Justice AE, Pers TH, Day FR, et al. Genetic studies of body mass index yield new insights for obesity biology. Nature. 2015;518:197-206.

PROFORMA

Sr. No.

NAME CR NO

AGE DOA

SEX DOD

ADDRESS

CHIEF COMPLAINTS

HISTORY OF PRESENTING ILLNESS

CO-MORBIDITIES--

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

GENERAL EXAMINATION

VITALS

BP

HR

HEIGHT

WEIGHT

BMI

SYSTEMIC EXAMINATION

CNS--

CVS—

RESPIRATORY--

ABDOMEN--

DIAGNOSIS

SIGNATURE OF CANDIDATE

SIGNATURE OF SUPERVISOR

INVESTIGATIONS (As per done)

TEST	DATE	DATE
Hb		
TLC/DLC/PLT		
HCT		
LFT		
RFT		
USG		
RBS		
LIPID PROFILE		
THROID PROFILE		
ECG		
ECHO		
BNP		
SLEEP STUDY		
OTHERS		

SIGNATURE OF CANDIDATE **SIGNATURE OF SUPERVISOR**

INFORMED PATIENT CONSENT

Date: _____

I.....D/o, W/o, S/o.....

am willing to participate in the study **"CLINICAL PROFILE OF OBESE PATIENTS".** The procedure with its complications has been explained to me in local vernacular language. I have fully understood that no special tests and extra expenditure in any form, merely forthe purpose of thesis is being carried out. I am free to opt out the study anytime without assigning any reason.

....

Signature of the Witness Signature of the patient

Name:

Signature of Candidate **Signature of Supervisor**

मरीज अनुमति फार्म

तिथि _____

मैं _____ पत्नी/पुत्र/पुत्री _____

निवासी _____

इस शोधकार्य "**CLINICAL PROFILE OF OBESE PATIENTS**" में भाग लेने के लिए सहमत हूँ। मैं इस शोधकार्य में भाग लेने के लिए अपनी स्वेच्छा से तैयार हूँ। मैं पुष्टि करता/करती हूँ की यह स्वीकृति देने के लिए मुझे कोई आर्थिक प्रलोभन नहीं दिया गया और न ही दबाव डाला गया है। मुझे इस शोधकार्य का उद्देश्य स्पष्ट कर दिया गया है और मुझे यह विश्वास है की यह विज्ञान और मानवता के लाभ के लिए है। मुझे इस शोधकार्य में होने वाले जोखिम के बारे में समझा दिया गया है और मेरी समझ में यह जोखिम बहुत मामुली है।

मैं इस शोधकार्य में भाग लेने के सम्बन्ध में किसी भी समय अपनी अस्वीकृति व्यक्त कर सकता/सकती हूँ और मेरे अस्वीकृति व्यक्त करने का मेरे इलाज पर कोई प्रभाव नहीं पड़ेगा।

_____ _____

गवाह के हस्ताक्षर रोगी के हस्ताक्षर/अंगूठे का निशान

नाम: नाम:

_____

अन्वेषक केहस्ताक्षर

_____

विद्यार्थी के हस्ताक्षर

ਮਰੀਜ਼ ਰਜ਼ਾਮੰਦੀ ਫਾਰਮ

ਮਿਤੀ_____

ਮੈ_____ਪਤਨੀ/ਪੁੱਤਰ/ਪੁੱਤਰੀ_____

ਵਾਸੀ _____

"CLINICAL PROFILE OF OBESE PATIENTS" ਤੇ ਚਲ ਰਹੀ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਰਜ਼ਾਮੰਦ ਹਾਂ। ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈ ਆਪਣੀ ਮਰਜ਼ੀ ਨਾਲ ਤਿਆਰ ਹਾਂ। ਮੈ ਇਹ ਦਸਣਾ ਚਾਹੁੰਦਾ ਹਾਂ/ ਚਾਹੁੰਦੀ ਹਾਂ ਕੇ ਇਹ ਰਜ਼ਾਮੰਦੀ ਦੇਣ ਵਾਸਤੇ ਮੈਨੂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦਾ ਲੋਭ-ਲਾਲਚ ਨਹੀ ਦਿੱਤਾ ਗਿਆ ਅਤੇ ਨਾ ਹੀ ਕੋਈ ਦਬਾ ਪਾਇਆ ਗਿਆ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਦਾ ਮਨੋਰਥ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਭਰੋਸਾ ਦਵਾਇਆ ਗਿਆ ਹੈ ਕੇ ਇਹ ਖੋਜ ਵਿਗਿਆਨ ਅਤੇ ਮਾਨਵਤਾ ਦੀ ਭਲਾਈ ਲਈ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਵਿਚ ਹੋਣ ਵਾਲੇ ਖਤਰੇ ਬਾਰੇ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਯਕੀਨ ਹੈ ਕੇ ਇਹ ਖਤਰਾ ਬਹੁਤ ਮਾਮੂਲੀ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਦਾ ਢੰਗ–ਤਰੀਕਾ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ।

ਮੈ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਬਾਰੇ ਆਪਣੀ ਰਜ਼ਾਮੰਦੀ ਕਿਸੇ ਵੀ ਸਮੇ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ/ ਸਕਦੀ ਹਾਂ ਅਤੇ ਮੇਰੀ ਰਜ਼ਾਮੰਦੀ ਵਾਪਸ ਲੈਣ ਦਾ ਮੇਰੇ ਇਲਾਜ ਤੇ ਕੋਈ ਅਸਰ ਨਹੀ ਹੋਵੇਗਾ।

_____ _____

ਗਵਾਹ ਦੇ ਹਸਤਾਖਰ ਮਰੀਜ਼ ਦੇ ਹਸਤਾਖਰ

ਮਿਤੀ_____ ਮਿਤੀ_____

ਪਤਾ _____ ਪਤਾ _____

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ਨਿਰੀਖਕ ਦੇ ਹਸਤਾਖਰ

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ਸਿਖਿਆਰਥੀ ਦੇ ਹਸਤਾਖਰ